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ABSTRACT

The general purpose of this study was to evaluate two community protective service systems in terms of the mechanisms for the identification and the handling of child abuse and neglect cases and the effectiveness of the intervention. Data were collected at two sites. One was a comprehensive 24-hour program, and the other was a more traditional system. Findings relevant to the nature and effectiveness of the systems' service interventions are reported. The monograph is sufficiently detailed to serve as a model for other programs. (Author/LFB)

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TWO COMMUNITY PROTECTIVE SERVICE SYSTEMS: NATURE AND EFFECTIVENESS OF SERVICE INTERVENTION

Prepared by: Clara L. Johnson Ph.D

Work supported in part by grant no. 10-P56015 from the Social and Rehabilitation Service, U.S. Department of Health, Education and Welfare.

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Preface

The general purpose of this study was to evaluate two community protective service systems in terms of the mechanisms for the identification and the handling of child abuse and neglect cases and the effectiveness of the intervention.

Data were collected in two sites. Site I, which has an emergency reporting system and a comprehensive 24-hour protective service program, is Nashville, Davidson County, Tennessee. In Site II, Savannah, Chatham County, Georgia, the protective service system is a more traditional one with no internal provision for 24-hour intake within the public welfare system.

This monograph reports the findings relevant to the nature and effectiveness of the systems' service intervention. An earlier monograph focused on their structure and case handling processes.

Acknowledgements

Were it not for the cooperation and hard work of many persons, the successful execution and completion of this study and this final report would not have been possible. Special recognition and thanks are due to:

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Finally, thanks are due to those patient and efficient typists who, in the end, made it all a realization–Vara Hunter for her efficiency and good humor in typing many drafts, and Christine Bennett for her keen perception of my errors during her most superb job of preparing the final report.

While I have requested and received valuable criticisms and suggestions from many persons, I assume full responsibility for any shortcomings of this report.

September, 1977

Chapter 1

INTRODUCTION

Background Statement

Children have been victims of maltreatment, physical and otherwise, from the beginning of time. It has only been within recent years, however, that society has defined child abuse and neglect as a social problem, one demanding solution in the interest of children, their families, and society in general. But the problem of maltreatment of children is not susceptible to ready solutions nor is the problem solvable by and through the efforts of any one profession.

There is one certain fact–the number of reported cases of child abuse and neglect is steadily increasing. This phenomenal increase in reported cases in recent years, coupled with the realization that reported cases do not reflect the actual incidence of maltreatment to children have caused increased national concern.

How can all the nation's children in need of protection be identified? How can the needs of abused and neglected children and their families best be met? Should more children and families be identified and reported, how, in the face of the diminishing service dollar, can the community honor its responsibility to provide services? These are but a few of the pressing questions plaguing the providers of protective services in communities throughout the country.

Of equal importance are questions which, if answered, could provide an informational base from which to work in seeking answers to the preceding questions. How are protective service systems presently operating? Is the responsibility for protective services viewed as a function of the "mandated" public agency or as a coordinated community-wide responsibility? What is the nature, quality, and outcome of the services being provided to those children and families who have already entered the protective services system?

In the not too distant past, the delivery of child protective services appeared to have been a relatively simple process–investigating, rescuing children, and prosecuting or otherwise punishing parents. There were fewer complexities then than now with regard to appropriateness of service plan decisions, legal issues, societal consequences and the like.

More recently, the general goal of protective services has changed from that of rescuing and prosecuting to that of casework and other ameliorative services. In the broadest sense, treatment in protective services is for the primary purpose of protecting children and modifying the behavior of the abusing or neglecting parent.

This philosophical stance has been included in the "Child Abuse Prevention and Treatment Act":

> . . . [P]rovide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation shall be initiated promptly to substantiate the accuracy of the report and, upon a finding of abuse or neglect immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect;
>
> . . . [D]emonstrate that there are in effect...such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with child abuse and neglect cases. . .[1]

The proposed regulations for the Act suggest multidisciplined multi-service resourced channels to deal with the problems of child abuse and neglect ". . . in order to protect the child and help strengthen the family, help the parents in their child rearing responsibilities, and if necessary, remove the child from a dangerous situation . . ."[2]

Protective service intervention, therefore, necessarily becomes, philosophically at least, a complex process initiated officially by the "mandated" public agency which involves the utilization of appropriate available community resources toward the dual goal of protecting children and rehabilitating families.

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[1] Public Law 93-247, 93rd Congress, S.1191 (January 31, 1974).

[2] Department of Health, Education, and Welfare, Office of Child Development. Proposed Rules for the Child Abuse Prevention and Treatment Program, *Federal Register*, Vol. 39, No. 168 (August 28, 1974), section 1340. 3-3(3)(ii).

Germane to the goal of protection and rehabilitation is a responsive and coordinated protective service system network which has the capability of delivering services appropriate to the needs of the abused and neglected children and their families.

Far too often, however, social service systems are not reflective of coordinated efforts. Beyond this, the appropriateness and therefore the effectiveness of given services is often seriously questioned.

There are many negative consequences of fragmented services to the consumers and to the agencies and/or other components responsible for service delivery. It stands to reason, that if the recipients of a system's services are not receiving services appropriate to their needs, then the system fails in its avowed mission. Beyond this failure–caused in part by fragmented services, agencies fail themselves, for much the same reason. Uncoordinated or fragmented systems do not readily lend themselves to documentation of services rendered and determination of the impact of those services. These two conditions often prompt agencies to seek additional needed funds.[3]

What services are delivered depends, in part, on available alternatives. In the main, however, two basic groups of services are normally available to protective service units: (1) services to children requiring placement outside the home, and (2) services to children and their families in their own home. What appears to be lacking, however, are criteria for making judgments concerning the appropriateness of given services and actions and at what point.[4] Another service delivery problem involves decisions pivotal to referrals. When should referrals be made and to what community resources?

Reference to actual cases from our Regional study of child abuse and neglect supports the presumption that decision-makers in the protective service system (including collateral systems such as courts, law enforcement, etc.) are faced with dilemmas in the service delivery process.[5]

Three such examples are cited below:

- Nine month old child taken to hospital with head, eye, and leg injuries. X-rays indicated no broken bones. Grandmother said she heard child's father beating child. Parents told different story regarding origin of injuries.

  Agency's disposition--confirmed abuse.

  Court's disposition--abuse ruled out.

  Consequence--within two weeks child DOA at hospital.

- An eleven month old male child found to have suspicious bruises by hospital physician. Child withdrew from human contact and cried when held. Also diagnosed as "failure to thrive." A sister, three years older was developing normally.

  Agency's disposition and recommendation--confirmed abuse and placement.

  Court's disposition--abuse ruled out and return child to parents' custody.

  Consequence--child later died under unusual circumstances.

- A twelve year old female was reported to protective services with bruises and welts. Both parents admitted that the child had been punished for stealing supplies from the home to sell at school.

  Agency's disposition--remain in home with services.

  Consequence--child reported in same year with bruises, welts, internal injuries, and malnutrition which were diagnosed as serious with probable permanent damage. As punishment,

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[3] For a discussion of consequences of fragmented services, see Marvin Rosenberg and Ralph Brady, *Systems Serving People: A Breakthrough in Service Delivery* (Cleveland, Ohio: Case Western Reserve University, School of Applied Social Sciences, 1974), pp. 1-3.

[4] Robert M. Mulford, "The Role and Function of Protective Services," *A National Symposium on Child Abuse* (Denver, Colorado: The American Humane Association, Children's Division, 1972), pp. 42-49.

[5] The results of the study have been reported in Clara L. Johnson, *Child Abuse in the Southeast: Analysis of 1172 Reported Cases* (Fall, 1974). Research monograph, Regional Institute of Social Welfare Research, University of Georgia.

the parents had severly beaten the child and withheld food for several days to get the "hardness" out of her.

Indeed, there are many problems involved in the delivery of protective services, especially in relation to decisions on legal issues, treatment modalities, modes of intervention on behalf of children, e.g., placement, and appropriateness of services. While the delivery of services cannot be problem free, criticisms concerning quality and effectiveness of services are beginning to mount.

As a means of anticipating frontal attacks, it appears that, as a first order of business, communities need to determine where they are with respect to the problem and to the nature and outcome of services rendered.

The present study addressed such issues in two counties, one each in two Southeastern States. The county or community is a crucial target for analysis in view of present social awareness of and concern about the fate of children.

With increasing frequency, the front pages of newspapers are covering details of serious abuse and/or neglect of children who, at the time of the "exposé" were or had previously been under "protective supervision" of or otherwise known to the mandated protective service agency or other community systems. Thus, in addition to standing concerns about the nature, the effects, the rising reported incidence, and causes of abuse and neglect, the issue of recidivism is becoming a major concern.

Hopefully, findings from this study–given its primary focus being on mechanisms for and the effectiveness of social intervention in child abuse and neglect cases–will give administrators some of the kinds of information needed to make modifications, if indicated, in their system's operations and to seek improvements in their agency environments.

Recap of Conceptual Framework

The systems model served as a conceptual framework for this research project. The use of the systems model, which can be viewed as an analytical tool for investigating the functions of interrelated parts which are crucial to the phenomenon being studied, was considered an appropriate framework for examining a community's approach to the delivery of protective services.[6]

Succinctly, a system is composed of a series of interrelated parts whose activities are coordinated according to a set of predefined rules and procedures. At the same time, an identified system includes subsystems and is part of a suprasystem.

The systems concept involves both an internal and external environment. The interaction of the system's components control and alter the internal environment. The external environment, which is not a part of and is, therefore, beyond the direct control of the system, consists of forces which act on and influence the system functioning.

The system, then, can be viewed in a dynamic sense as a network of channels within specified or predetermined boundaries through which products, services, resources, and information flow within the system and between the system and its environment.

The analysis of a service system involves examining input, operations or conversion processes, i.e., the coordinated actions and activities of the various parts which control and are controlled by the environment, and system output.

Inputs are generally viewed as resources and client input. Resource input, namely, staff, funds, and available services are active inputs which are used by the system to process clients. Client inputs are used by the system or acted upon in order for the system to realize its major goals.

Input also includes feedback or information flow. Feedback can be defined as "... a signal from the operating system about its functioning and relationship with its environment."[7] Such input, if used, allows the system to determine and correct malfunctions in its own operations and to seek changes in the environment.

Given inputs, i.e., resources, clientele, as well as restrictions, e.g., in the form of limitations of public opinion, attitudes, and administrative constraints, a social service system can be viewed as a process which transforms input elements into (hopefully) desirable products. Systems operations or

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[6] For a more detailed discussion of the conceptual framework see Chapter 2 in Clara L. Johnson, *Two Community Protective Service Systems: Comparative Evaluation of Systems Operations*. (Research monograph: Regional Institute of Social Welfare Research, University of Georgia), March, 1976.

[7] Rosenberg and Brody, p. 13.

the conversion process refers to the total process of assessing and serving clients; this includes negotiations with internal and external environments toward the end of goal realization.

System outputs refer to activities of and services rendered by the system. Outputs are distinguishable from outcomes which refer to the impact of the services on the processed clients who have passed through the system, i.e., as they relate to previously specified objectives and reflect changes in the problem or client need status. While output information allows a system to view and assess its activities in terms of its objectives, it is outcome information which allows the system to evaluate the effectiveness of the activities and services.

The relationship of the elements in a social systems analysis is described by Rosenberg and Brody who indicate that a ". . . system takes in inputs across this boundary (input process), engages in a conversion process by transforming these inputs and then exports the products of the system as outputs across the boundary."[8]

In our research we have, through design, attempted to determine and assess these relationships and the relationship of the identified systems to other systems as a means of gaining insight into the community network for the delivery of protective services.

While the larger study provided data germane to the major elements of the systems model, this report is primarily addressed to input, output, and outcome with discussions of operations data where indicated. In an earlier monograph, which was devoted to an analysis of systems operations, we reported findings from which insights were gained on mechanisms for handling protective service cases in the two study sites.[9] The primary goal of the research efforts, on which the monograph was based, was to determine, describe, and evaluate the internal functioning of the protective service units and their relationship to the parent agency, i.e., the public welfare agency. Beyond these considerations, the report deals with the relationship between the protective service system and major collateral systems to gain insights into the community network for the protection of abused and neglected children.

[8] *Ibid.*, p. 12.

[9] Johnson, *Two Community Protective Service Systems.*

In regard to our utilization of the systems model as a conceptual framework for the total study, we have consciously tried not to become bogged down in a play of strict technical jargon. Rather, our approach has been simply to utilize the tool as a framework for data collection and analysis and a comprehensible format for presenting the results. We did not propose to add nor detract from the development of systems analysis as a methodological procedure.

Methodology of the Study

This research project was officially launched in the Fall of 1973 with data collection beginning in the Spring of 1974. The concerns which gave impetus to the project emanated from some of the issues emerging out of our Region IV study of child abuse and neglect, the results of which have been analyzed, reported, and distributed nationally in two research monographs.[10]

General Objectives

The following objectives guided the research process:

1. To determine, at the local level, the organization and structure of protective service delivery systems.

2. To determine and assess the nature and content of services delivered.

3. To determine the effectiveness of the protective service delivery systems.

4. To develop models for training and service delivery systems based on insights gained from the findings.

Research Design

This project was developed as evaluation research utilizing an exploratory-descriptive design. Evaluation research involves the collection of data for the purpose of assessing the

[10] Clara L. Johnson, *Child Abuse: State Legislation and Programs in the Southeast* (August, 1973) and *Child Abuse in the Southeast: Analysis of 1172 Cases* (Fall, 1974). Research Monographs, Regional Institute of Social Welfare Research, University of Georgia.

impact of a program or a system's functioning. Given constraints imposed by limited man power, the nature of the system, time and funding available for research efforts, many evaluation research efforts are limited in focus to one or possibly two of the major elements of a system, namely, inputs, operations, outputs, and/or outcomes. The present research was based on data relevant to all of the components.

The exploratory-descriptive design was selected due to the nature of the research, i.e., identification of the issues and constraints affecting service to consumers. The major emphasis in the exploratory study is on the discovery of ideas and insights. This means that the research design must be flexible enough to allow for the consideration of various aspects of the phenomenon under study. Descriptive information does not involve any explicit statements of causal relationships.

Data Sources and Research Procedures

Data for this study were collected in Nashville, Davidson County, Tennessee and Savannah, Chatham County, Georgia. In the Nashville site an emergency 24-hour reporting system with a unique protective service program (CES--Comprehensive Emergency Services) had been in effect since 1971. As a basis for planning for the program which was funded as a demonstration project by the Office of Child Development, D.H.E.W., the Urban Institute of Washington, D.C. conducted a study of neglected and dependent children in Metropolitan Nashville in 1970-71. In Savannah, Chatham County, Georgia, the protective service system was a more traditional one with no internal provision for 24-hour emergency reporting within the public welfare system.

This research project was conceptualized in two levels. The primary goal of Level I was the delineation of the systems' mechanisms for the identification and the handling of child abuse and neglect cases, i.e., program structure and organization. The major goal of Level II was to determine and evaluate the nature and effectiveness of the systems' intervention.

Level I data which served as the data source for the analysis of systems operations or process issues were obtained from several sources in each site. In Nashville, these kinds of data were obtained from interviews with CES personnel, direct on-site observation, and two major reports: (1) one representing findings from an evaluation study of protective services in Nashville,[11] and (2) an in-house survey of medical facilities.[12]

In Savannah interviews with instruments of a structured and semi-structured format were conducted with administrative and service workers in the protective service unit of DHR,[13] with similar level personnel in the police department, in four hospitals and the public health department, and with court workers. Additionally, on-site observations of the system's operations were utilized.

Thus, the data for the operations or process component of the two systems were not from entirely comparable sources. Obviously, having embarked on a research effort on a project for which evaluative research had been conducted as in the case of Nashville's CES project and a system on which similar research had not been carried out, we could not utilize the same type of procedures as if we had conducted our research activities in two sites with similar programs and at similar stages of program development. Actually, one of the values in the study, we feel, is in the comparisons we were able to make of two very dissimilar systems for the delivery of protective services to abused and neglected children. Beyond this, we do not feel that the efficacy of the findings is violated by this approach for two major reasons: (1) the exploratory-descriptive design allows flexibility in the data collection process, and (2) the systems flow charts, constructed as a result of the data collected and the on-site observations, were reviewed for accuracy by project personnel with systems' representatives in each site. Additionally, a draft copy of the monograph reporting systems operation was shared with representatives in each site for comments and/or corrections prior to the final printing.

Level II data, which served as the data base for issues relevant to systems input, output, and outcome--the major focus of the present monograph--were obtained in each site through structured interviews with protective service staff

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[11] Marvin R. Burt and Louis H. Blair, *Options for Improving the Care of Neglected and Dependent Children, Nashville-Davidson County, Tennessee*. (Washington, D.C.: The Urban Institute, 1971).

[12] Survey of Twelve Hospitals, Nashville-Davidson County, Tennessee. Report prepared by Donna J. Drinnon, Region V, Tennessee Department of Public Health (October, 1973). The survey was conducted in October-November, 1972.

[13] DHR refers to the Department of Human Resources which is Georgia's department of public welfare services. Throughout the remainder of this report we will refer to the Department of DHR.

and a structured schedule to which case data were transferred from agency records by our research project staff.

Prior to transferring Level II case data to optical scan sheets from which IBM computer cards were punched, each schedule was edited by project personnel. As a result of our editorial work, a total of 119 additional cases were deemed unusable for one or more of the following reasons: (1) nature of cases was not included in our working definition of child abuse and neglect, (2) cases became first known to the mandated protective service agency during our data collection phase, and (3) reported incidents prior to the most current occurred in areas other than the study sites.

Level II data relevant to the evaluation of the effectiveness of intervention were computer processed but manually analyzed. Succinctly, individual case data rather than aggregated data were analyzed to determine systems outcome.

The total caseload for this study was analyzed by decks of case data from each protective service system. Deck 1 refers to serial abuse cases for which there was a deck 3–a prior incident--and perhaps a deck 4, an even earlier incident. Deck 2 refers to cases on which only one incident had been investigated.

Evaluation of Systems Operations–Level I

With respect to the goal of determining and assessing the mechanisms for the identification and the handling of child abuse and neglect cases in the two study sites, criteria presumed to be basic to the realization of a protective service system's delivery functions or activities were conceptualized. These activities, and evaluation criteria, which were basic to Level I of the research project and reported on in detail in the first volume of this study, are outlined below.[14]

Functions/Activities.–A system's functions or activities are, in effect, the components through which the system operates. The major functions of a protective service system, as we view them are:

1. *Coordination and Cooperation with the Environment.*–The protection of children is a community affair, one in which many systems may and must become involved if the protective service program is to be a success. Viewing the protection of children in this manner, it logically becomes an expected function of the system, mandated to protect abused and neglected children, to initiate and/or maintain a well coordinated and cooperative relationship with its environment.

2. *Intake.*–Entrance into the protective service system occurs through intake. The intake function involves the screening of cases to determine the nature of the action to be taken.

3. *Screening.*–While screening can and is generally considered an aspect of the intake process, we have chosen to treat screening as a separate function or activity as each system handled the process in distinctly different ways.

4. *Investigation.*–The investigation, through which the validity of complaints is determined, has probably always been a major activity of protective service systems. However, in view of the mandate in Public Law 93-247, requiring that the State provides for an investigation of every reported known or suspected instance of abuse or neglect, we can assume that the investigatory function will become increasingly more important as a protective service system activity.

5. *Case Assignment.*–Case assignment as a function may be related both to investigation and to case handling. In relation to the investigatory function, the assignment of cases appears to be based on assumptions regarding the nature of the incident and the severity of the injuries or the neglectful conditions. The assignment of cases for "management" purposes seems to be based on the above assumptions as well as structural and organizational aspects of the system.

6. *Case Handling.*–Responsibility for planning and coordination, referrals and/or court petitions, and on-going delivery of services to children and their families, i.e., follow-up, are elements of the case handling function.

[14] Johnson, *Two Community Protective Service Systems.* Functions, criteria for evaluating systems operations, and contributory factors are discussed in Chapter 3.

7. *Record Keeping.*–Record keeping is the process of maintaining data which can be utilized for the general purposes of accountability, showing effectiveness of services, and for internal decision-making functions.

Evaluation Criteria.–The following set of criteria was used in evaluating how the systems operated in terms of the functions. This list of criteria was in no way considered inclusive, nor did every criterion relate to the evaluation of every function.

1. *Expediency as a Criterion.*–This criterion refers to the immediacy with which the mandated protective service system responds to reports of abuse or neglect. The measure of expediency was determined by a consideration of the time which expired between the time the report was received and the time of official action, i.e., investigation. The data for these calculations were obtained from case records. Beyond this, a determination of expediency was based on the existence of intra and interagency linkages and coordination in the response process.

2. *Compliance as a Criterion.*–There are two aspects of this criterion. First, incidence coverage is defined as the extent to which cases identified by collateral systems are reported to the mandated protective service system. Secondly, investigatory coverage refers to the extent to which the recipient of reports investigates relevant cases. To determine incidence coverage, we considered the question of who may and who does report to the mandated protective service system. Similarly, respondents in the collateral systems were asked if, when, to whom, and under what circumstances they reported identified cases of abuse and neglect. To determine investigatory coverage, the responses to the question, "Are all cases investigated?", were considered. The question was asked in relation to neglect and abuse complaints.

3. *Efficiency as a Criterion.*–Efficiency, generally meaning productivity of action with minimum waste, was based on the extent of coordinated and cooperative efforts in internal operations and in relation to the parent agency and to the external environment. To determine the nature of such relationships, interviewees in the protective service system and in the collateral systems were asked to describe procedures of operating from the point of identification. Further, the respondents were asked if the outlined procedures were uniform/routine. In addition, a comparison of system' personnel performing functions was considered.

4. *Operational Definition of Abuse and Neglect as a Criterion.*–An operational definition of what constitutes abuse or neglect was considered to exist if the following conditions were present: (1) written policy describing conditions and priorities set for responding to reports, and (2) case handling predicated on a distinction between emergency intervention and long-term services. Beyond this, gross inconsistencies among respondents to the question, "If cases are confirmed as a result of investigation, what actions are then taken by your agency?", suggested a lack of definitional clarity. Interviewees were asked to consider a list of abusive and neglectful situations having serious and non-serious consequences for children.

Evaluation of Effectiveness–Level II

The following set of criteria was utilized to evaluate the systems' intervention, i.e., services rendered.

1. *Recidivism as a Criterion.*–The extent to which children did not return to the system as measured by the absence of subsequent reports was considered an indication of the effectiveness of intervention. We acknowledge the fact that the inability to control for such relevant variables as family mobility, failures in the reporting system, and the occurrence of injuries not detected by potential reporters, lessens the validity of recidivism as a criterion.

2. *Length of time Between Reported Incidents as a Criterion.*–Longer periods of time between incidents was considered a measure of effectiveness. Here, too, the factors that tend to

lessen the validity of recidivism as a criterion warrant that inferences be made with caution.

3. *Severity of Subsequent Harm as a Criterion.*– This criterion was predicated on the assumption that if services were effective, subsequent reported incidents would involve harm less serious in nature than prior incidents.

4. *Rehabilitation of Perpetrator as a Criterion.*– To the extent that reported incidents did not involve the same perpetrator(s) and/or the same type(s) of harm to the children, we inferred that services were effective.

5. *Disposition of Agency as a Criterion.*–In utilizing agency disposition as a criterion, the assumption was made that subsequent dispositions would either remain the same or be less severe than earlier dispositions, e.g., services in the home over against removal.

The above criteria have allowed us to make inferences about the services rendered by both systems under study. However, the limitations of the criteria as measures of effectiveness are both realized and acknowledged. It is understood that the best measures of effectiveness would be those which indicate some direct impact on the lives of the children and their families, e.g., growth and development factors, family rehabilitation, etc., over time (longitudinal design). A less accepted though more direct study design, would involve post-measures of subjects who have been abused and those identified as abusers. For the scope of this study, neither avenue was open. Thus, while the present study (Level II data) has the advantage of a time-series look at case data in terms of reported incidents, a major weakness with respect to the evaluation of effectiveness has been the lack of measures of personal growth and development and family rehabilitation.

Case Selection

As indicated earlier, data for Level II of the study were generated from two major sources--the staff of the protective service system (CPS Unit) and case records.

One problem we have learned to expect in conducting research in which our samples are to be drawn from agency records is that of determining the size of the population from which samples must be drawn. The major reason for this problem, we have found, is that most agencies by their own admission cannot supply precise figures due, in part, to flaws in record keeping operations. With this limitation in mind–that of working with rough estimates–our procedure for the selection of cases is outlined below.

In both sites the narrative accounts of reported incidents of abuse and neglect were maintained in family folders; that is, the unit for record keeping was the family. For our research purposes, we studied records of all families in the child protective service caseload which were reported between August, 1971 and April, 1973 for abuse and neglect according to our predetermined definitions.[15] The selection of cases was based on the nature of the complaint (definition) and a determination of one child per family.

Cases were considered for this study if they involved: (1) abandonment, (2) physical harm which was not accidental or otherwise ruled out by the worker/agency, (3) neglect either from deliberate acts designed to result in neglect, e.g., withholding of food, placing children out-of-doors in inclement weather as a form of punishment, etc. or acts designed for an unrelated purpose which result in neglect, e.g., leave child unattended while out on "the town," (4) neglect resulting primarily from parental inadequacies in child rearing practices, home management, etc., (5) sexual abuse, and (6) emotional abuse which was determined on a case-by-case basis from the narrative case account.

In terms of case selection, we excluded all cases which resulted from one or more of the following: (1) accidental injuries, (2) neglect due to family illness/hospitalization, (3) family crisis which could have negative consequences for familial stability, e.g., death, and (4) personal report involving voluntary placement of children in the absence of abuse and neglect. The logic for the exclusion of the above types of cases is two-fold: (1) such cases were not handled by Savannah's Protective Service Unit (PSU), and (2) while the welfare of children and their families are at stake in such cases, the decisions made and the treatment required are basically different from that involved in cases generally defined as abuse and neglect.

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[15] The Nashville system which was designed as a crisis intervention system was responsive to situations other than those involving abuse and neglect. According to the then Director of the CES project, approximately sixty percent of the cases they handled were abuse and neglect.

As indicated earlier, one abused and/or neglected child per family was selected for inclusion in the study. If there was more than one abused and/or neglected child in the family, a schedule was completed for the child representing repeated abuse. If more than one child represented repeated abuse, the child reported most often was used. If none of the children represented repeats, a schedule was completed on the youngest child. If all of the children had been reported more than once but for the same number of times, a schedule was completed on the oldest child who was yet under the care of the parent or guardian.

Thus, our sample of cases represents the total population of families in each site that was reported during the period of study for abuse and neglect according to our definition. It is to be emphasized, however, that the number of cases included in our study does not represent incidence kinds of data.

Major Considerations

This research project had as its overall goal the evaluation of two communities' mechanisms for and effectiveness of the delivery of protective services from a systems perspective. Various management considerations during the life of the study necessitated reporting the findings in two monographs. Level I results which summarized systems operations or processes were reported in the earlier referenced monograph entitled, *Two Community Protective Service Systems: Comparative Evaluation of Systems Operations*.

This report summarizes all the system's components, input-process-output, together in a holistic picture. And to the extent the data allow, an evaluation of the services rendered by each system has been made.

A second consideration must be strongly emphasized, namely, that our research effort in Nashville, Davidson County, Tennessee did not represent an evaluation of CES as a conceptual framework for the delivery of protective services.[16] In terms of the objectives guiding CES as a demonstration project, evaluation studies by Marvin Burt and Ralph Balyeat have indicated program success.[17] The present study has been an attempt to analyze the operating CES program from a broader context of protective service delivery in Nashville from the perspective of the systems model. The CES system is being compared to the formal system of protective service delivery in Savannah, Chatham County, Georgia. *Thus, the objectives guiding this study have been imposed upon the systems analyzed rather than reflecting the explicit objectives of either system. Therefore, our findings should not be construed as an indictment of either system or the recommendation of one over the other.*

A third consideration which is an extension of the latter and is presented simply as a word of caution involves the very nature of evaluative research. While evaluative research may provide a wealth of feedback information which can be utilized in decision making, program evaluation can be considered a dangerous thing even when conducted completely without intended bias. In view of negative evaluation, a program might be discarded in favor of one which, even in the absence of evaluation, appears to be more promising. By the same token, a positive evaluation might result in the acceptance, adoption, and diffusion of the program aspects by staff and agencies similar in function. According to Suchman, evaluative research is necessarily judgmental--its major function being that of determining the value of goal-oriented activities, i.e., whether objectives are being attained by certain activities.[18] Therefore, we urge first that readers be mindful of the fact that results of an evaluative study relate to specific objectives and the measurement of certain activities designed to attain the objectives. Second, the objectives which guided the present study and our evaluation processes do not necessarily reflect the explicit objectives of either system we analyzed.

Additional issues for the reader's consideration will be discussed at relevant points in the report.

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[16] When the grant funds for CES as a demonstration project ended, a national grant was obtained for the purpose of disseminating information on the CES system and the development of training packages for communities desiring to set up similar programs.

[17] Marvin R. Burt and Ralph Balyeat, "A New System for Improving the Care of Neglected and Abused Children," *Child Welfare*, Volume LIII, Number 3 (March, 1974).

[18] Edward A. Suchman, "Action for What? A Critique of Evaluative Research" in Richard O'Toole (ed.), *The Organization, Management, and Tactics of Social Research* (Cambridge, Mass.: Schenkman, 1972), pp. 97-130.

Limitations of the Study

One of the major limitations of the study rests in our inability to analyze and discuss the reported incidence of child abuse and neglect in the two systems studied. One of the reasons for this limitation results from our case selection procedure; namely, one child from each family. More importantly, the systems differed in the scope of problems included in their child protective service caseload. A third and equally important reason for this limitation was that the procedures for case documentations within both systems failed to account for the "true" incidence of reported abuse and neglect.

A second limitation, which is a corollary of the latter and of our analytical design, i.e., the analysis of serial abuse and isolated incident cases separately, is the relatively small number of cases in both systems' caseloads. This limitation was more acutely felt in our individual case analyses from which we inferred effectiveness of intervention. We shall discuss this limitation in more detail in Chapter 5 in which findings relevant to intervention are presented and discussed.

A third limitation involves the subjective nature of the data regarding family circumstances. Institute personnel interpreted the narrative accounts of the workers' assessment of the families in our sample. Percentages representing presence or absence of particular family characteristics, however, represent a conservative picture due to the fact that if certainty of presence or absence could not be established, we considered the status of the circumstance to be unknown. This limitation will be discussed further in Chapter 5.

Finally, not having access to specifics on the availability of community and agency funds as resource inputs severely limited the insights we might have gained regarding constraints encountered in the systems in processing clients.

Summary of Level I Findings

The efforts in Level I of the research project were directed toward a comparative evaluation of the two protective service delivery systems in terms of the criteria outlined earlier in this report.

Efforts were made to identify salient similarities and differences, and to pinpoint factors which impeded or enhanced the systems in their operations process.

We found that both systems were impeded in their internal operations as a result of the state of their relationship with collateral community systems. Operations were influenced negatively on two levels, one resulting from limited input from these collateral systems and the other from the ways these systems handled abuse and neglect cases.

In relation to both the CES (Nashville) and the PSU (Savannah) systems, we found that collateral systems, especially hospitals, provided limited input. Input via law enforcement and court systems in Nashville was provided on a more uniform basis than in Savannah. While limited input from collateral systems is a major concern from the standpoint of the failure to provide services to children and families in need, from a system's standpoint, the inappropriate handling of cases by other systems poses more problems for the delivery of services by the protective service system; i.e., impedes the orderly sequencing of services, making their delivery difficult or impossible.

At the time of the study, collateral systems in both communities fell short in their responsibility of channeling abused and neglected children into the protective service system. At the same time, mechanisms for receiving children in the two protective service systems differed materially. The 24-hour intake provision in the CES system was a major plus, while the lack of intake beyond DHR's work hours or a coordinated procedure with intake in the law enforcement or Juvenile Court system was a definite impediment to PSU's operations. Given this lack in the PSU system, a sudden increase in input from collateral systems in Savannah would probably be less than desirable from an operational standpoint.

Related to intake capabilities are the procedures for investigating complaints. In the CES system both aspects were intricately tied to Juvenile Court operations. Conjoint coordinated approaches to investigation in emergency or crisis situations allowed for the on-site presence of social service assessment and court authority. Seemingly, too, coordinated intake and investigatory procedures contributed to the expediency with which investigations were initiated and to the total coverage of case reports. Reportedly, all complaints were investigated that could not be referred to other community resources or otherwise deflected from CES.

This latter point is made primarily with the fact in mind that the number of intake personnel in the CES project was at the time of the study the same as the number

of personnel in the PSU. Further, it bears noting that intake workers in CES were responsible for an average caseload of approximately forty cases in which children were at different stages in the protective service process.

On the other hand, PSU workers were not responsible for an active long-term caseload. Thus, in terms of the differences in county size (Davidson County, Tennessee–approximately 500,000 and Chatham County, Georgia–less than 200,000) and given a comparable number of key casework personnel, systems efforts at coordination in Davidson County, Tennessee must be responsible in part for the differences in expediency and coverage capabilities.

A major advantage the CES system had over the PSU in Savannah was the component services which could be brought to bear upon emergency situations without the vicissitudes of bureaucratic red tape. Some of the similar kinds of services, e.g., homemakers, were available in other service components of the Georgia Department of Human Resources (DHR), but such services were not available to the PSU without formal requests, eligibility determination, and other procedural processing. Thus, their utility for "crisis" intervention was virtually nil.

One of the major features of an emergency or crisis intervention system (such as the CES) is immediacy in response to complaints via investigations and ameliorative services and the successful movement of cases to other community resources or on-going units in the larger system. The operations of CES became increasingly difficult, i.e., intake workers' caseloads became increasingly larger, due, in part, to problems encountered in case transferrals. These difficulties were related both to intake workers' failure (within CES) to operationally define crisis and to the less than desirable relationship between CES and its parent social service agency. The ease with which cases were transferred between PSU in Savannah and other service components of DHR was a decided plus over CES operations.

In both systems, the record keeping approach had negative effects upon their operations. In Nashville, the major data recording log reflected an inflated picture of child abuse, but at the same time serial abuse was captured. In Savannah, the major data recording log reflected a deflated picture without capturing serial abuse cases. Both systems recorded only "cold" facts on case handling; "hot" facts were imbedded within the mire of process recordings and other information within the workers' folders on the families.

In recognizing the preceding factors, it can again be stated that each system had particular strengths in operations, but neither system had all of the strengths that might be desirable in the delivery of services to children entering the protective service system.

Chapter 2

SYSTEMS CLIENT INPUT: WHO ARE THE CHILDREN ENTERING THE SYSTEM?

Who are our nation's abused, neglected, and otherwise maltreated children? It is a commonly held assumption that the phenomenon of child abuse and neglect crosses racial and socioeconomic lines and reveals little sex or age discrimination. Those who enter the protective service system, however, generally represent a disproportionate percent of the poor, nonwhites, the young, and a slightly higher percent males.

This section of the chapter is devoted to the two systems' client input, with discussions of the major characteristics of the abused and neglected children who entered the systems, the nature and severity of the harm they suffered, and the familial circumstances under which they lived. Of particular interest to the following discussions are the insights gained from the analysis of the data by the nature of the case--serial abuse cases and cases on which only one incident had been reported.[1]

Children and Families Served in the CES System Nashville, Davidson County, Tennessee

Age, Sex and Race

Of the 234 cases in the total caseload, 54.8 percent of the children were less than six years of age; 26.9 percent were ten years and older. Of the children under six years of age, 35.1 percent were under three with 16.7 percent being less than one.

The findings indicate that the age distribution of reported maltreated children is highly represented by the young child. Perhaps, a more significant finding is the difference noted between the two categories of cases--serial abuse and isolated incident cases--with respect to the age distribution. While the distribution of the total caseload, without consideration of the nature of the case, differed minimally from that which is generally discovered, a close observation of the data in Table 2-1 indicates that there is a great deal of disparity between the overall distribution and that of the separate types of cases.

The apparent which surfaces is the tendency for children among serial abuse cases to be older than those on whom one known report had been made. Among serial abuse cases, 47.2 percent were less than six years of age, with only 5.7 percent being under one, 23.6 percent under the age of three and in the three to less than six age category. Among isolated incident cases, over sixty percent of the children were less than six years old, with a high of 25.8 percent under one year of age, 44.5 percent under the age of three, and 16.4 percent in the three to less than six age range.

An unexpected observation was the finding that there was a relatively high percent of children age ten and above among the isolated incident cases (23.4) as well as among the serial abuse cases (31.1).

The differences in the age distribution by the nature of the case will take on more meaning in a subsequent section when the severity of harm is discussed.

Of the cases for which sex was known (N=229), there were slightly more females in the total caseload than were males, 51.1 and 48.9 percent, respectively. For 2.1 percent of the cases sex was unknown. In observing the sex of children by the nature of the case, however, it is noted in Table 2-2 that the percentage distribution is reversed for the decks of cases--a slightly higher percent of males were among the serial abuse cases.

There were 220 cases for which race was known; of these, 76.4 percent were white and 23.6 percent were black. The race of children by the nature of the case, however, presented a slightly different distribution, with a higher percent of all black children being among the serial abuse cases and a higher percent of all white children among the isolated incident cases.

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[1] The total caseload was separated into two decks of case data for analytical purposes. Deck 1 represented serial abuse cases and Deck 2 was cases of children on whom only one known report had been made. Cases in Deck 1 also served as the data base for the evaluation of effectiveness of intervention which is discussed in Chapter 5.

TABLE 2-1

Age of Children by Nature of Case

Nature* of Case	Age of Children																				Total
	Under 1 Year		1 to < 2 Years		2 to < 3 Years		3 to < 6 Years		6 to < 8 Years		8 to < 10 Years		10 to < 12 Years		12 to < 14 Years		14 to < 16 Years		16 to < 18 Years		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Serial Abuse Cases	6	5.7 (15.4)	9	8.5 (47.4)	10	9.4 (41.7)	25	23.6 (54.3)	12	11.3 (57.1)	11	10.4 (50.0)	12	11.3 (54.5)	5	4.7 (55.6)	13	12.3 (72.2)	3	2.8 (21.4)	106 (45.3)
Isolated Incident Cases	33	25.8 (84.6)	10	7.8 (52.6)	14	10.9 (58.3)	21	16.4 (45.7)	9	7.0 (42.9)	11	8.6 (50.0)	10	7.8 (45.5)	4	3.1 (44.4)	5	3.9 (27.8)	11	8.6 (78.6)	128 (54.7)
Total N & %	39	16.7	19	8.1	24	10.3	46	19.7	21	9.0	22	9.4	22	9.4	9	3.8	18	7.7	14	6.0	234
Cumulative %				24.8		35.1		54.8		63.8		73.2		82.6		86.4		94.1		100.0	

Column percentages are presented in parentheses; other percentages are based on row totals.

*Throughout the report serial abuse refers to cases analyzed as Deck 1 and isolated incident to those analyzed as Deck 2.

TABLE 2-2

Sex and Race of Children by Nature of Case

Nature of Case	Sex					Race				
	Male		Female		Total	White		Black		Total
	N	%	N	%		N	%	N	%	
Serial Abuse Cases	53	51.0 (47.3)	51	49.0 (43.6)	104	74	72.5 (44.0)	28	27.5 (53.8)	102
Isolated Incident Cases	59	47.2 (52.7)	66	52.8 (56.4)	125	94	79.7 (56.0)	24	20.3 (46.2)	118
Total	112	48.9	117	51.1	229	168	76.4	52	23.6	220

Age and Race by Nature of Case

Having determined the age and race distributions of the children reported, we decided to note the age of these children by race. We determined earlier that: (1) 35.1 percent of the total caseload were less than three years of age with 16.7 percent being less than one year old; (2) a much higher percent of children on whom one report had been made were less than three (44.5) as compared to those among serial abuse cases (23.6); (3) a higher percent of all black children (53.8) were among serial abuse cases than were the percent of all white children (44.0).

The age distribution by race for the total caseload was similar for both white and black children, with 55.3 percent of the white and 53.8 percent of the black being less than six years of age. A discrepancy in the age distribution by race existed in the two oldest age categories. A higher percent (21.2) of the black children than the percent of the white children (10.7) were ten to less than fourteen. The reverse was true for those fourteen and older–16.1 percent of the white and 5.8 percent of the black children.

The analysis of age and race data by the nature of the case revealed further irregularities. While we noted earlier that a higher percent of all black children were among serial abuse cases than were the percent of all white children, we found a higher percent of the black children among isolated incident cases under the age of three (58.3 percent) than the percent of white children (41.5 percent). On the other hand, among the serial abuse cases there was a higher percent of white children under age 3 (28.4 percent) than the percent of black children (14.3 percent). Of the white children among serial abuse cases, 21.6 percent were three to less than six years old; this compares to 28.6 percent of the black children. This situation was reversed among isolated incident cases where only 8.3 percent of the black and 18.1 percent of the white were three to less than six. A higher percent of the black children among serial abuse and isolated incident cases were in the age category of ten to less than fourteen. On the other hand, a higher percent of the white children in both categories of cases were age fourteen and above.

These data which are presented in Table 2-3 reveal that there was a tendency for black children among isolated incident cases to be younger than white children; white children among serial abuse cases tended to be younger than black children. Further, a higher percent of white children than black children were found among both types of cases in the age category of fourteen and above.

Which category(s) of these children were more likely to be victims of repeated reports of maltreatment? A look at the percent of children among serial abuse cases as opposed to the percent among isolated incident cases provided some insight. In Table 2-4, it can be noted that at every age level, with the exception of the less than three, the percent of all black children among serial abuse cases was higher than the percent of all white children.

TABLE 2-3

Age and Race of Children by Nature of Case

Race	Age Level										
Serial Abuse Cases	< 3		3 < 6		6 < 10		10 < 14		14 < 18		Total
	N	%	N	%	N	%	N	%	N	%	
White	21	28.4	16	21.6	16	21.6	9	12.2	12	16.2	74
		(84.0)		(66.6)		(69.6)		(56.3)		(85.7)	72.5
Black	4	14.3	8	28.6	7	25.0	7	25.0	2	7.1	28
		(16.0)		(33.3)		(30.4)		(43.8)		(14.3)	27.5
Total	25	24.5	24	23.5	23	22.5	16	15.7	14	13.7	102
Isolated Incident Cases	N	%	N	%	N	%	N	%	N	%	
White	39	41.5	17	18.1	14	14.9	9	9.6	15	16.0	94
		(73.6)		(89.5)		(82.4)		(69.2)		(93.8)	79.7
Black	14	58.3	2	8.3	3	12.5	4	16.7	1	4.2	24
		(26.4)		(10.5)		(17.6)		(30.8)		(6.3)	20.3
Total	53	44.9	19	16.1	17	14.4	13	11.0	16	13.6	118
Total Caseload	N	%	N	%	N	%	N	%	N	%	Total
White	60	35.7	33	19.6	30	17.9	18	10.7	27	16.1	168
		(76.9)		(76.7)		(75.0)		(62.1)		(90.0)	
Black	18	34.6	10	19.2	10	19.2	11	21.2	3	5.8	52
		(23.1)		(23.3)		(25.0)		(37.9)		(10.0)	
Total	78	35.1	43	19.5	40	18.2	29	13.2	30	13.6	220

TABLE 2-4

Percent of Children Among Serial Abuse Cases by Age and Race*

Race	Age of Children										Total
	<3 Years		3<6 Years		6<10 Years		10<14 Years		14<18 Years		
	N	%	N	%	N	%	N	%	N	%	
White	21	35.0	16	48.5	16	53.3	9	50.0	12	44.4	74
Black	4	22.2	8	80.0	7	70.0	7	63.6	2	66.6	28
Total	25	35.5	24	19.5	23	18.2	16	13.2	14	13.6	102

*Numbers for age levels are Deck 1 data found in Table 2-3. Percentages are based on the number of Deck 1 children in each age category as a percent of the total number of children in each age category.

For all white children under the age of three, 21 or 35.0 percent (N=60) were among the serial abuse cases; this compared to 4 or 22.2 percent (N=18) of the black children. For all white children, age three but less than six, 48.5 percent were among the serial abuse cases–80.0 percent of the black children. Sixteen or 53.3 percent of all white children and seven or 70.0 percent of all black children in the six to less than ten age range represented multiple report cases. Of the white children, age ten to less than fourteen, 50.0 percent were among the serial abuse cases; this compared to 63.6 percent of the black children. Similarly, for the children age fourteen but less than eighteen, 44.4 percent of the white and 66.6 percent of the black were among the serial abuse cases.

Sex and Race by Nature of Case

From Table 2-5, we note that there is minimal difference between serial abuse and isolated incident cases with respect to the distribution of the sexes for white children. This does not hold true for the black children. It becomes readily apparent that black males were more likely than any other category of children to have been victims of repeated reports of maltreatment. Of a total of 83 white males in the total caseload, 37 or 44.6 percent represented serial abuse cases. This compares to 43.4 percent of the 83 white females. Black females were represented by a similar percentage among serial abuse cases (42.9 percent). On the other hand, of 24 black males, 16 or 66.7 percent were among serial abuse cases.

TABLE 2-5

Sex and Race of Children by Nature of Case

Race	Sex of Children											
	Serial Abuse*				Isolated Incident				Total Caseload			
	Male		Female		Male		Female		Male		Female	
	N	%	N	%	N	%	N	%	N	%	N	%
White	37	50.7 (69.8)	36	49.3 (75.0)	46	49.5 (85.2)	47	50.5 (74.6)	83	50.0 (77.6)	83	50.0 (74.8)
Black	16	57.1 (30.2)	12	42.9 (25.0)	8	33.3 (14.8)	16	66.7 (25.4)	24	46.2 (22.4)	28	53.8 (25.2)
Total	53	52.5	48	47.5	54	46.2	63	53.8	107	49.1	111	50.9

*Statistical tests were just below the .05 level of significance for the association between race and sex for serial abuse cases.

Age, Sex, Race, and Nature of Case

There appeared to be a pattern between age and sex for white children in the total caseload. A higher percent of the white males (44.6 percent) were under the age of three; this compares to 25.3 percent females. On the other hand, a higher percent of the females were reported in the age category of fourteen and above–21.7 percent female to 10.8 percent male. In considering the data by the nature of the case, we found the major deviation from the pattern to exist among serial abuse cases where the difference between males and females reported in the age fourteen and above category was less pronounced. There were 6 or 16.2 percent of the males and 6 or 16.7 percent of the females.

The N's on which percentages for black children were based are small; however, the general pattern was found to hold in the total caseload–39.1 percent males to 28.6 percent females under three years of age and 4.3 percent male to 7.1 percent female age fourteen and above. A noted deviation was the relatively high percent of the females under one year of age among both isolated incident cases and the total caseload. See Table 2-6.

Types of Abuse Reported

Physical abuse which was determined not to be related to disciplinary measures and neglect resulting from parental inadequacies were, by far, the most frequently reported types of abuse for both the children who had been previously reported and those involved in single incidents. The third most frequent form was abandonment.

When we noted the types of abuse by race and the nature of the case, variations were found in the distribution. Among serial abuse cases, neglect due to parental inadequacies and physical abuse unrelated to disciplinary action remained the most prevalent form of abusive treatment for white children. On the other hand, abandonment, physical abuse of a non-disciplinary nature, and neglectful conditions resulting from the absence of parent(s) were equally reported for black children.

Among isolated incident cases, the forms of abuse remained unchanged for white children, however, physical abuse was the most prevalent. Among blacks, physical abuse for which the motive could not be determined and the category including other unspecified types emerged as the most frequent forms of abuse. See Table 2-7.

Seriousness of Harm Suffered

Approximately one-third of the total caseload involved serious consequences to the child. However, a higher percent of children among the isolated incident cases were seriously harmed (36.7 percent) than were those among serial abuse cases (29.2 percent). Of the serious cases in the total caseload, over sixty percent were among the isolated incident cases.

Similarly, a higher percent of the children among the isolated incident cases were known to have been hospitalized. These data are reported in Table 2-8.

In regard to seriousness of harm by race and nature of the case, a higher percent of cases involving serious consequences for both black and white children were among the isolated incident cases. Slightly less than thirty percent for both races were serious in the serial abuse and more than thirty-five percent serious among the isolated incident cases.

Seriousness of harm by age and race is presented in Table 2-9. Of the total caseload, 56 or 37.3 percent of the white children suffered serious harm, with 51.8 percent of all serious cases being less than three years of age, 73.2 percent under the age of six, and 16.1 percent ten years and over. There were differences in the age distribution of serious cases by the two categories of cases–serial abuse and isolated incident cases.

While a higher percent of isolated incident cases were serious than were serial abuse cases, a higher percent of those among serial abuse were less than six (77.3 percent) as compared to those who had been reported only once (70.5 percent). On the other hand, the older children who were victims of repeated abusive treatment were less likely than those among isolated cases to have been seriously harmed. Only 9.1 percent of the serial abuse cases as compared to a high of 20.6 percent of the isolated incident cases in which the children were age ten and above were seriously harmed.

Similarly, of the total number of black children for whom all relevant variables were known, 17 or 36.2 percent were seriously harmed, with 47.1 percent of all serious cases being less than three years of age, 64.7 percent under the age of six, and 17.6 percent ten years and above.

The age distribution of serious cases involving black children by the nature of the case differed somewhat from that

TABLE 2-6

Age, Race and Sex of Children by Nature of Case

Age	Race and Sex of Children															
	White								Black							
	Total Caseload				Serial Abuse				Isolated Incident				Total Caseload				Serial Abuse				Isolated Incident			
	Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
< 1 year	17	70.8 (20.5)	7	29.2 (8.4)	4	80.0 (10.8)	1	20.0 (2.8)	13	68.4 (28.2)	6	31.6 (12.8)	3	30.0 (13.0)	7	70.0 (25.0)	0	--	0	--	3	30.0 (37.5)	7	70.0 (43.8)
1 < 2	7	50.0 (8.4)	7	50.0 (8.4)	2	28.6 (5.4)	5	71.4 (13.9)	5	71.4 (10.9)	2	28.6 (4.2)	5	100.0 (21.7)	0	--	2	100.0 (13.3)	0	--	3	-- (37.5)	0	--
2 < 3	13	65.0 (15.7)	7	35.0 (8.4)	5	62.5 (13.5)	3	37.5 (8.3)	8	66.7 (17.3)	4	33.3 (8.5)	1	50.0 (4.3)	1	50.0 (3.6)	1	100.0 (6.7)	0	--	0	--	1	-- (6.2)
3 < 6	16	48.5 (19.3)	17	51.5 (20.5)	9	56.2 (24.3)	7	43.8 (19.4)	7	41.2 (15.2)	10	58.8 (21.2)	6	60.0 (26.1)	4	40.0 (14.2)	5	62.5 (33.3)	3	37.5 (25.0)	1	50.0 (12.5)	1	50.0 (6.2)
6 < 8	5	35.7 (6.0)	9	64.3 (10.8)	2	25.0 (5.4)	6	75.0 (16.7)	3	50.0 (6.5)	3	50.0 (6.3)	1	20.0 (4.3)	4	80.0 (14.2)	1	25.0 (6.7)	3	75.0 (25.0)	0	--	1	100.0 (6.2)
8 < 10	5	31.2 (6.0)	11	68.8 (13.2)	4	50.0 (10.8)	4	50.0 (11.1)	1	12.5 (2.1)	7	87.5 (14.9)	3	60.0 (13.0)	2	40.0 (7.1)	3	100.0 (20.0)	0	--	0	--	2	100.0 (12.5)
10 < 12	8	57.1 (9.6)	6	42.9 (7.2)	4	50.0 (10.8)	4	50.0 (11.1)	4	66.7 (8.7)	2	33.3 (4.2)	1	16.7 (4.3)	5	83.3 (17.9)	1	33.3 (6.7)	2	66.7 (16.7)	0	--	3	100.0 (18.8)
12 < 14	3	75.0 (3.6)	1	25.0 (1.2)	1	100.0 (2.7)	0	--	2	66.7 (4.3)	1	33.3 (2.1)	2	40.0 (8.7)	3	60.0 (10.7)	1	25.0 (6.7)	3	75.0 (25.0)	1	100.0 (12.5)	0	--
14 < 16	6	40.0 (7.2)	9	60.0 (10.8)	5	50.0 (13.5)	5	50.0 (13.9)	1	20.0 (2.1)	4	80.0 (8.5)	1	50.0 (4.3)	1	50.0 (3.6)	1	50.0 (6.7)	1	50.0 (8.3)	0	--	0	--
16 < 18	3	25.0 (3.6)	9	75.0 (10.8)	1	50.0 (2.7)	1	50.0 (2.8)	2	20.0 (4.3)	8	80.0 (17.0)	0	--	1	100.0 (3.6)	0	--	0	--	0	--	1	100.0 (6.2)
Total	83		83		37		36		46		47		23		28		15		12		8		16	

TABLE 2-7

Types of Abuse by Nature of Case

Race	Types of Abuse																			
	Abandonment		Physical Abuse/ Discipline Related		Physical Abuse Unrelated to Discipline		Emotional Abuse		Neglect Child home/ Parent Absent		Neglect Parent-Child Home		Neglect Parental Inadequacies		Sexual Abuse		Physical Abuse Motive Undetermined		Other	
Serial Abuse	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	11	11.1	8	8.0	17	17.2	9	9.0	7	7.0	12	12.1	20	20.2	4	4.0	5	5.0	6	6.0
Black	7	17.9	4	10.3	7	17.9	2	5.1	7	17.9	5	12.8	4	10.2	1	2.6	1	2.6	1	2.6
Isolated Incident	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	19	15.8	14	11.7	24	20.0	11	9.2	11	9.2	4	3.3	18	15.0	5	4.2	6	5.0	8	6.7
Black	4	11.8	2	5.9	2	5.9	2	5.9	1	2.9	4	11.8	6	17.6	1	2.9	6	17.6	6	17.6
Total Caseload	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	30	13.7	22	10.0	41	18.7	20	9.1	18	8.2	16	7.3	38	17.4	9	4.1	11	5.0	14	6.4
Black	11	15.0	6	8.2	9	12.3	4	5.5	8	11.0	9	12.3	10	13.7	2	2.7	7	9.6	7	9.6

Percentages are based on number of children. Percentages do not add up to 100 since over 30 percent of the children sustained more than one form of maltreatment.

TABLE 2-8

Seriousness of Harm by Nature of Case

Nature of Case (Deck No.)	Seriousness							Physician Seen?							Hospitalized?						
	Not Serious		Serious		Unknown		Total	Yes		No		Unknown		Total	Yes		No		Unknown		Total
	N	%	N	%	N	%		N	%	N	%	N	%		N	%	N	%	N	%	
Deck 1 (Serial Abuse)	63	59.4 (47.4)	31	29.2 (39.7)	12	11.3 (52.2)	106 (45.3)	43	40.6 (45.3)	47	44.3 (45.2)	16	15.1 (45.7)	106	16	15.1 (36.4)	63	59.4 (46.7)	27	25.5 (49.1)	106
Deck 2 (Isolated Incident)	70	54.7 (52.6)	47*	36.7 (60.3)	11	8.6 (47.8)	128 (54.7)	52	40.6 (54.7)	57	44.5 (54.8)	19	14.8 (54.3)	128	28	21.9 (63.6)	72	56.3 (53.4)	28	21.9 (50.9)	128
Total	133	56.8	78	33.3	23	9.8	234	95	40.6	104	44.4	35	15.0	234	44	18.8	135	57.7	55	23.5	234

*Includes one (1) fatal case.

TABLE 2-9

Seriousness of Harm by Age, Race, and Nature of Case

Age	Deck 1 (Serial Abuse) Not Serious		Deck 1 (Serial Abuse) Serious		Deck 1 (Serial Abuse) Total	Deck 2 (Isolated Incident) Not Serious		Deck 2 (Isolated Incident) Serious		Deck 2 (Isolated Incident) Total	Total Caseload Not Serious		Total Caseload Serious		Total Caseload Total
Seriousness - White Children															
< 3	10	47.6 (23.8)	11	52.4 (50.0)	21	17	48.6 (32.7)	18	51.4 (52.9)	35	27	48.2 (28.7)	29	51.8 (51.8)	56
3 < 6	8	57.1 (19.0)	6	42.9 (27.3)	14	10	62.5 (19.2)	6	37.5 (17.6)	16	18	60.0 (19.1)	12	40.0 (21.4)	30
6 < 10	9	75.0 (21.4)	3	25.0 (13.6)	12	10	76.9 (19.2)	3	23.1 (8.8)	13	19	76.0 (20.2)	6	24.0 (10.7)	25
10 < 14	7	100.0 (16.7)	0	--	7	6	75.0 (11.5)	2	25.0 (5.9)	8	13	86.7 (13.8)	2	13.3 (3.6)	15
14 < 18	8	80.0 (19.0)	2	20.0 (9.1)	10	9	64.3 (17.3)	5	35.7 (14.7)	14	17	70.8 (18.1)	7	29.2 (12.5)	24
Total	42	65.6	22	34.4	64	52	60.5	34	39.5	86	94	62.7	56	37.3	150
Seriousness - Black Children															
< 3	2	50.0 (11.1)	2	50.0 (25.0)	4	6	50.0 (50.0)	6	50.0 (66.7)	12	8	50.0 (26.7)	8	50.0 (47.1)	16
3 < 6	5	71.4 (27.8)	2	28.6 (25.0)	7	1	50.0 (8.3)	1	50.0 (11.1)	2	6	66.7 (20.0)	3	33.3 (17.6)	9
6 < 10	5	71.4 (27.8)	2	28.6 (25.0)	7	1	50.0 (8.3)	1	50.0 (11.1)	2	6	66.7 (20.0)	3	33.3 (17.6)	9
10 < 14	4	66.7 (22.2)	2	33.3 (25.0)	6	3	75.0 (25.0)	1	25.0 (11.1)	4	7	70.0 (23.3)	3	30.0 (17.6)	10
14 < 18	2	100.0 (11.1)	0	--	2	1	100.0 (8.3)	0	--	1	3	100.0 (10.0)	0	--	3
Total	18	69.2	8	30.8	26	12	57.1	9	42.9	21	30	63.8	17	36.2	47

Table does not include unknowns.

of the white children.We noted earlier that black children were more likely than were white children to have been victims of repeated abusive treatment. Yet, the seriousness of harm to black children was less pronounced among serial abuse cases (30.8 percent) than among isolated incident cases (42.9 percent). In regard to the age distribution, over sixty percent of the black children among isolated incident cases who were seriously harmed were under the age of three. This compares to slightly more than fifty percent of the white children.

We might be reminded here of the general age distribution for the races by the nature of the case. More whites than blacks among serial abuse cases were under the age of three; 28.4 and 14.3 percent, respectively. A higher percent of the black children among isolated incident cases were less than three (58.3 percent); this compares to 41.5 percent of the white children.

Again, it is apparent from the above findings, as in other studies, that the young are more likely to suffer serious consequences from abusive treatment.

Regarding seriousness of harm by race and sex, a slightly higher percent of the cases involving white females were serious than the percent of those involving white males among both types of cases. For black children, the opposite was found in both types of cases. For the total number of cases of black children, 40.9 percent of the males and 32.0 percent of the females were seriously harmed. This compares to 35.1 percent of the white males and 37.8 percent of the white females. The seriousness of harmed suffered was more pronounced for all the children among isolated incident cases, with well over fifty percent of the black males in such cases being seriously affected. Thus, black males were the most likely group of children to be both victims of repeated abusive treatment and to be seriously harmed. See Table 2-10 for these findings.

Prior Reported Abuse of Children

Of a total of 234 cases, 106 or 45.3 percent represented cases on which at least one incident prior to the most current had been reported to the CES system; 128 or 54.7 percent were isolated--single reported incident--cases.

Of the serial abuse cases (N=106), 67 or 63.2 percent had only one known recorded prior report, 26 or 24.5 percent had two prior reports; 10 or 9.4 percent had three; and 3 or 2.8 percent had four or more.

According to the data presented in Table 2-11, males were reported more often than were females, with 79.2 percent of the males and 96.1 percent of the females having been reported two or fewer times previously. At the other extreme, approximately twenty percent of the males and less than four percent of the females had been reported at least three times previous to the most current report.

We determined earlier that black children were more likely than were white children to have been victims of prior abuse. According to Table 2-12, a slightly higher percent of black children had been reported three or more times--14.3 of the black and 12.3 percent of the white.

Without controlling for race which undoubtedly has some effect on the results, we noted a peculiar finding with respect to age and prior reports. The oldest children were more likely than were the youngest to have only one prior reported incident--72.0 percent of the less than three as compared to 87.5 percent of the fourteen and older. The middle age categories--six to less than ten with slightly more than sixty percent and ten to less than fourteen with slightly less than fifty percent--were more likely than the other age categories to have two or more prior reports. Beyond the effect race could have on these findings, perhaps our selection of case procedure compounded the results. See Table 2-13 for the detailed distribution.

Prior Placement of Children

Sixteen children or approximately fifteen percent of the children who had been victims of repeated reports of abuse (N=106 serial abuse cases) had at least one known prior official placement.

Of the children that had prior placements, 10 or 62.5 percent were male. This represents 18.9 percent of the males among serial abuse cases. By comparison, 11.8 percent of the females among serial abuse cases had a prior placement history.

Regarding race, a higher percent of the white children (68.8 percent) were among the sixteen known to have a placement history. However, the percent of black children with a placement history (5 or 17.9 percent) was greater than the percent of white children (11 or 14.9 percent).

On matters of age and prior placement for the serial abuse cases, children in the middle age categories--six to less than ten with 5 or 31.3 percent and ten to less than fourteen

TABLE 2-10

Seriousness of Harm by Race, Sex, and Nature of Case

Seriousness of Harm	Deck 1 (Serial Abuse) Male N	Deck 1 (Serial Abuse) Male %	Deck 1 (Serial Abuse) Female N	Deck 1 (Serial Abuse) Female %	Deck 1 (Serial Abuse) Total	Deck 2 (Isolated Incident) Male N	Deck 2 (Isolated Incident) Male %	Deck 2 (Isolated Incident) Female N	Deck 2 (Isolated Incident) Female %	Deck 2 (Isolated Incident) Total	Total Male N	Total Male %	Total Female N	Total Female %	Total
Sex of White Children															
Not Serious	21	50.0 (67.7)	21	50.0 (65.6)	42 (66.7)	27	51.9 (62.8)	25	48.1 (59.5)	52 (61.2)	48	51.1 (64.9)	46	48.9 (62.2)	94 (63.5)
Serious	10	47.6 (32.3)	11	52.4 (34.4)	21 (33.3)	16	48.5 (37.2)	17*	51.5 (40.5)	33 (38.8)	26	48.1 (35.1)	28	51.9 (37.8)	54 (36.5)
Total	3	49.2	32	50.8	63	43	50.6	42	49.4	85	74	50.0	74	50.0	148
Sex of Black Children															
Not Serious	10	55.6 (66.7)	8	44.4 (72.7)	18 (69.2)	3	25.0 (42.9)	9	75.0 (64.3)	12 (57.1)	13	43.3 (59.1)	17	56.7 (68.0)	30 (63.8)
Serious	5	62.5 (33.3)	3	37.5 (28.3)	8 (30.8)	4	44.4 (57.1)	5	55.6 (35.7)	9 (42.9)	9	52.9 (40.9)	8	47.1 (32.0)	17 (36.2)
Total	15	57.7	11	42.3	26	7	33.3	14	66.7	21	22	46.8	25	53.2	47

Unknowns not included in table.
*Includes one (1) fatal case.

TABLE 2-11

Sex and Prior Reported Incidents

Sex	Number of Prior Incidents								Total
	1		2		3		4 or More		
	N	%	N	%	N	%	N	%	
Male	30	56.6 (46.2)	12	22.6 (46.2)	8	15.1 (80.0)	3	5.7 (100.0)	53
Female	35	68.6 (53.8)	14	27.5 (53.8)	2	3.9 (20.0)	0	—	51
Total	65	62.5	26	25.0	10	9.6	3	2.9	104

TABLE 2-12

Race and Prior Reported Incidents

Race	Number of Prior Reported Incidents								Total
	1		2		3		4 or More		
	N	%	N	%	N	%	N	%	
White	47	63.5 (74.6)	18	24.3 (69.2)	7	9.5 (70.0)	2	2.7 (66.7)	74
Black	16	57.1 (25.4)	8	28.6 (30.8)	3	10.7 (30.0)	1	3.6 (33.3)	28
Total	63	61.8	26	25.5	10	9.9	3	3.0	102

TABLE 2-13

Age and Prior Reported Incidents

Age	Number of Prior Reported Incidents								Total
	1		2		3		4 or More		
	N	%	N	%	N	%	N	%	
< 3	18	72.0 (26.9)	5	20.0 (19.2)	2	8.0 (20.0)	0	—	25
3 < 6	17	68.0 (25.4)	5	20.0 (19.2)	2	8.0 (20.0)	1	4.0 (33.3)	25
6 < 10	9	39.1 (13.4)	10	43.5 (38.5)	4	17.4 (40.0)	0	—	23
10 < 14	9	52.9 (13.4)	5	29.4 (19.2)	2	11.8 (20.0)	1	5.9 (33.3)	17
14 < 18	14	87.5 (20.9)	1	6.3 (3.8)	0	----	1	6.3 (33.3)	16
Total	67	63.2	26	24.5	10	9.4	3	2.8	106

with 4 or 25.0 percent of the total placements--as with the number of prior reports, were more likely than those in the other age groupings to have a prior placement. For the above specified groupings, the cases with prior placements represent 21.7 percent of the 23 children age six to less than ten and 23.5 percent of the 17 children age ten to less than fourteen. Surprisingly, only 2 or 12.5 percent of the children age fourteen and above had a prior placement.

Relationship of the Main Perpetrators

Mothers or mother substitutes were identified as the main perpetrator in well over sixty percent of the cases, with fathers or father substitutes being the main perpetrator in less than thirty percent. These findings are at variance with those from both the Regional and National studies where a lower percent female to a higher percent male were so identified.

Perhaps, the above unexpected finding can be explained, in part, by one or all of the following:

1) Our data collection process involved an indepth study of the workers' narrative accounts of incidents and familial circumstances in general from which we were perhaps better able to capture information which is usually not reported on specified forms;

2) As co-perpetrators in the present study, fathers or father substitutes accounted for over fifty percent as compared to less than twenty-five percent mother or mother substitutes; and

3) There may well be some association between the identity of the perpetrator and the type of abusive treatment involved.

Pursuing the latter line of thinking, we noted the serial abuse cases on which we performed individual case rather than aggregated data analyses for purposes of determining effectiveness of intervention (see Chapter 5). We found that in cases in which physical abuse either as a single form of abuse or in conjunction with other forms of abuse was present, fathers or father substitutes were the main perpetrator in over forty percent of the cases. On the other hand, mothers or mother substitutes were generally the named perpetrator when abandonment and forms of neglect were the case.

The findings regarding relationship of the perpetrators persisted when we held race constant. According to Table 2-14, black mothers or mother substitutes accounted for over seventy percent of the perpetrators in relation to black children in the total caseload. This compares to less than sixty-five percent of the white. Black fathers or father substitutes were identified in less than twenty percent of the cases involving black children, while white fathers or father substitutes were identified in slightly over thirty percent.

According to Table 2-15, white mothers or mother substitutes were more likely than were black mothers or mother substitutes to mete out serious harm to their children. Of the total number of cases in which white mothers or mother substitutes were involved, over thirty percent resulted in serious harm to the children. This compares to slightly more than twenty percent for the black mothers or mother substitutes. The difference, however, took on more meaning when we noted seriousness by the nature of the case. Among isolated incident cases, the differences were less pronounced; harm was serious in 32.2 percent of the cases in which white mothers were the perpetrator with seriousness being unknown for 8.5 percent, and in 27.8 percent of the cases in which black mothers were the perpetrator with seriousness unknown for 16.6 percent.

Thirty percent of the cases for white mothers and 15.0 percent for black mothers were serious in the serial abuse caseload. Perhaps these differences can be explained, in part, by the types of abusive treatment which were most prevalent for the races among the two categories of cases. According to data presented in Table 2-7, the types of abusive treatment associated with white children remained virtualy unchanged by the nature of the case. On the other hand, among serial abuse cases for black mothers two major forms of abusive behavior which need not necessarily result in immediate measurable harm--abandonment and neglect with the child being home and parent being absent--were present in over thirty-five percent of the cases. Thus, we might have at least a partial explanation for the low percentage of serious cases for black children among serial abuse cases.

White fathers or father substitutes were more likely than were white mothers to be involved in cases which resulted in serious harm. Of the total number of cases in which white fathers or father substitutes were the perpetrator, more than thirty-five percent were serious as compared to 31.2 percent for white mothers. While there was little difference noted for the percent of serious cases for white mothers or mother substitutes, white fathers identified as the perpetrator in

TABLE 2-14

Relationship of the Main Perpetrator by Race and Nature of Case

Race of Perpetrator	Mother/ Mother Substitute N	%	Father/ Father Substitute N	%	Other Relative N	%	No Relationship N	%	Total
Perpetrator - Serial Abuse Cases									
White	50	67.6 (71.4)	22	29.7 (81.5)	2	2.7 (66.7)	0	--	74
Black	20	71.4 (28.6)	5	17.9 (18.5)	1	3.6 (33.3)	2	7.1 (100.0)	28
Total	70	68.6	27	26.5	3	2.9	2	2.0	102
Perpetrator - Isolated Incident Cases									
White	59	62.8 (76.6)	29	30.9 (85.3)	2	2.1 (66.7)	4	4.2 (100.0)	94
Black	18	75.0 (23.4)	5	20.8 (14.7)	1	4.2 (33.3)	0	--	24
Total	77	65.3	34	28.8	3	2.5	4	3.4	118
Perpetrator - Total Caseload									
White	109	64.9 (74.1)	51	30.4 (83.6)	4	2.4 (66.7)	4	2.4 (66.7)	168
Black	38	73.1 (25.9)	10	19.2 (16.4)	2	3.8 (33.3)	2	3.8 (33.3)	52
Total	147	66.8	61	27.7	6	2.7	6	2.7	220

isolated incident cases were responsible for a substantially higher percent of serious abuse cases (41.4 percent) than were those in serial abuse cases (27.3 percent).

While the N was small for black fathers or father substitutes, we noted that percentage-wise they were responsible for the highest percent of serious abuse cases among both types of cases.

Family Circumstances

Complete and detailed information on the characteristics and circumstances of families of abused and neglected children would yield an invaluable data base for those interested in and working with such children and their families. Such objective and detailed information, however, is usually unavailable on large numbers of families. Overall, the present study was no exception in this regard. However, the information obtained on families of children who had been known to the protective service agency over time was more complete and detailed than that of families who had come to the attention of the agency as a result of a single report.

Inasmuch as a great deal of narrative data, pertinent forms, and miscellaneous materials were available in the majority of serial abuse cases and often times little such data, beyond the "cold" facts incorporated on the required reporting form, existed for isolated incident cases, a discussion of

TABLE 2-15

Seriousness of Harm by Relationship of Perpetrator, Race, and Nature of Case

Relationship of Perpetrator	Serial Abuse Cases						Isolated Incident Cases						Total Caseload					
	Not Serious		Serious		Unknown		Not Serious		Serious		Unknown		Not Serious		Serious		Unknown	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Seriousness of Harm - White Children																		
Mother/Mother Substitute	21	54.0 (64.3)	15	30.0 (68.2)	8	16.0 (80.0)	35	59.3 (68.6)	19	32.2 (57.6)	5	8.5 (62.5)	62	56.9 (66.7)	34	31.2 (61.8)	13	11.9 (72.2)
Father/Father Substitute	14	63.6 (33.3)	6	27.3 (27.3)	2	9.1 (20.0)	14	48.3 (27.4)	12	41.4 (36.4)	3	10.3 (37.5)	28	54.9 (30.1)	18	35.3 (32.7)	5	9.8 (27.8)
Other Relative	1	50.0 (2.4)	1	50.0 (4.5)	0	--	1	50.0 (2.0)	1	50.0 (3.0)	0	--	2	50.0 (2.2)	2	50.0 (3.6)	0	--
No Relationship	0	--	0	--	0	--	1	50.0 (2.0)	1	50.0 (3.0)	0	--	1	50.0 (1.0)	1	50.0 (1.8)	0	--
Total	42	56.7	22	29.7	10	13.5	51	55.4	33	35.9	8	8.7	93	56.0	55	33.1	18	10.8
Seriousness of Harm - Black Children																		
Mother/Mother Substitute	16	80.0 (84.2)	3	15.0 (37.5)	1	5.0 (50.0)	10	55.6 (83.3)	5	27.8 (62.5)	3	16.6 (100.0)	26	68.4 (83.9)	8	21.1 (50.0)	4	10.5 (80.0)
Father/Father Substitute	3	50.0 (15.8)	3	50.0 (37.5)	0	--	2	50.0 (16.7)	2	50.0 (25.0)	0	--	5	50.0 (16.1)	5	50.0 (31.3)	0	--
Other Relative	0	--	1	100.0 (12.5)	0	--	0	--	1	100.0 (12.5)	0	--	0	--	2	100.0 (12.5)	0	--
No Relationship	0	--	1	50.0 (12.5)	1	50.0 (50.0)	0	--	0	--	0	--	0	--	1	50.0 (6.2)	1	50.0 (20.0)
Total	19	65.5	8	27.5	22	6.8	12	52.2	8	34.8	3	13.0	31	59.6	16	30.8	5	9.6

only the circumstances known to be present, therefore, might distort or prejudice the picture of families who had been known to the protective service agency through several reported incidents. As a means of balancing such an occurrence, perhaps a discussion of the circumstances, in terms of their known absence as well, might provide a more valid indication of familial circumstances and conditions under which the children lived.

The complete percentage distribution of the circumstances and/or conditions by the nature of the case is presented in Table 2-16. This section will be limited to a brief discussion of selected circumstances. See Table 2-17 for the percentage distribution of the circumstances by race.

We found that the known family circumstances and/or living conditions of the children and their families who had previously been reported (serial abuse cases) differed somewhat in several important aspects from that of children who had not been reported prior to the current reported situation (isolated incident cases). While this is true, the reader is cautioned in interpreting the findings due to the limitation in the data particularly in relation to isolated incident cases.

Parents Evidence Intellectual Inadequacies.--It has been recognized that some child abusers are mentally retarded while a large proportion are pathetically uninformed and/or unlearned. In view of the fact that the presence or absence of the familial condition, which includes both general types of intellectual inadequacies, was based on the subjective evaluation of workers and on project staff's assessment of the total family case record, caution should be taken in interpreting these findings.

There was little difference between the percent of parents among serial abuse cases (26.7 percent) and those among isolated incident cases (24.2 percent) who were "determined" to have noticeable problems in intellectual functioning. Such problems were known to be absent in a higher percent of serial abuse cases (34.3 percent) than in the isolated incident cases (27.3 percent).

In well over fifty percent of the cases, there was limited data on parental problems in intellectual capacities. From what is known, however, there appeared to be little difference between the parents in the two categories of cases. This finding generally persisted when we noted the presence or absence by race.

Mother Shows Evidence of Sexual Promiscuity and/or Drug or Alcohol Abuse.--Possibly due to workers' keen awareness of such problems and/or a predisposition to label, knowledge of the presence or absence of this circumstance was known for both types of cases in approximately seventy percent of the cases--in 78.3 percent of the serial abuse and in 68.8 percent of the isolated incident cases. Mothers or mother substitutes among serial abuse cases were more likely than were mothers among isolated incident cases to evidence these kinds of problems. The problems of sexual promiscuity, drug and/or alcohol abuse were present for 61.3 percent and absent for only 17.0 percent of the mothers of children who were victims of repeated abuse. By comparison, such problems were present for 39.1 percent and absent for 29.7 percent of mothers among isolated incident cases.

Based on the percentages present and absent in relation to unknowns by race, black mothers among serial abuse cases (92.9 percent) were more likely than any other group of mothers to evidence these kinds of problems.

Parents Evidence Emotional/Psychological Problems.--Data were unknown for both types of cases in well over sixty percent of the cases. From the data which were known, however, it appears that in general these families were beset with emotional/psychological problems. Such problems were identified for 67.0 percent of the parents among serial abuse cases and known to be absent in only 7.5 percent. Of the parents among isolated incident cases, 59.4 percent evidenced problems of an emotional/psychological nature, with only 7.8 percent known to be free of such problems.

In regard to race, there were no marked differences; however, there was a tendency for the occurrence to be more likely among white parents whose children had been previously reported (68.9 percent). A high percent of the black parents among isolated incident cases (62.5 percent) also evidenced such problems.

History or Evidence of Prior Physical Abuse to Child.--For serial abuse cases, the information was known in well over ninety percent of the cases with the condition being present in 80.2 percent and known to be absent in 15.1 percent. While isolated incident cases had not been previously reported, evidence existed in 36.5 percent which pointed to prior abuse to the child. There was a tendency, however, for such problems not to exist among these families; in over forty percent of the isolated incident cases no evidence was present.

There was little difference when race was held constant. Such evidence, however, was most likely to exist for whites among serial abuse cases.

Parents Experiencing Marital Problems.--Information of this nature was known in over seventy percent of both categories of cases. From the known information, a relatively high percent of parents of children among both types of cases were experiencing marital problems. Over forty percent of the parents among serial abuse cases and over thirty percent of the parents among isolated incident cases were determined to have marital problems. Such problems were known to be absent in 32.1 percent and 37.8 percent of the serial abuse and isolated incident cases, respectively. Black families were less likely to be plagued by marital problems.

Parents Experiencing Temporary Financial Problems.--Parents of children who were victims of repeated reports of abuse appeared to be more likely than parents of children who had not been previously reported to be experiencing temporary financial problems. This circumstance was known to be present for over fifty percent of the former and less than thirty percent of the latter. Similarly, the circumstance was absent in only 12.3 percent of the serial abuse cases as compared to 24.2 percent of the isolated incident cases.

There was negligible difference between the races in regard to this circumstance. Both white and black families among serial abuse cases were more likely than those among isolated incident cases to be plagued by temporary financial problems.

Family of Low Subsistence and General Living Level.--The data suggest that, by and large, parents of children who were victims of repeated abuse lived at a low socio-economic level. This information was known in slightly less than eighty percent of the serial abuse cases with the condition known to be present in 77.4 percent and absent in 11.3 percent. By comparison, 47.7 percent of the parents of children among the isolated incident cases were known to subsist at a low economic level; this living condition was determined to be absent in 25.0 percent of these cases.

Blacks were more likely than whites to live at a low subsistence and general living level. Of the black families of children among serial abuse cases, 89.3 percent as compared to 74.3 percent of the white, were known to live at a low economic level. The living circumstance was absent among serial abuse cases for zero percent and 11.3 percent of black and white families respectively. Among isolated incident cases 75.0 percent of the black and 41.5 percent of the white lived at a low subsistence level. Only 8.3 percent of the black as compared to 28.7 percent of the white were known to live reasonably free of economic pressures. Both black and white families of children among serial abuse cases were more likely than those of children who were involved in an isolated incident to live at a low subsistence level.

Neglect is Chronic.--Neglect as a chronic condition was more likely to characterize children among serial abuse cases than those among isolated incident cases. Among serial abuse cases, the condition was present in 62.9 percent of the cases and absent in only 15.1 percent. This compares to 28.9 percent present and 36.2 percent absent among isolated incident cases.

Child Evidences Intellectual Inadequacies.--From the known data, children who were victims of repeated abuse were more likely than those involved in a single reported incident to have known problems in intellectual functioning. Such problems were evident in 18.9 percent of the former and 10.2 percent of the latter. By the same token, a lower percent of the children who had been repeatedly abused were known not to evidence intellectual inadequacies. Deviations of this nature were absent for 40.6 percent of the serial abuse cases compared to 52.3 percent of the isolated incident cases.

Child Evidences Emotional/Psychological Problems.--Here again, children among serial abuse cases were more likely than those among isolated incident cases to possess emotional/psychological problems. Among serial abuse cases, such problems were present for 35.8 percent and absent for 19.8 percent. This compares to 21.9 percent present and 39.8 percent absent among isolated incident cases.

Too Many Children in Family for Income and/or Dwelling.--It was noted earlier that families of children among serial abuse cases were more likely to live at a low economic level. Related to this finding is the finding which indicates that such families were also more likely to be comprised of large numbers of children. The condition of too many children was present in 45.3 percent and absent in 31.1 percent of such families. By comparison, only 18.0 percent of the families among isolated incident cases were so characterized, with 54.7 percent known not to have excessively large families.

In regard to this family characteristic by race, black families were more likely than white families to have too many children. The pattern between categories of cases, however, did not persist. Among serial abuse cases, 35.1 percent of the white and 71.4 percent of the black had too many children. This condition was known to be absent in

TABLE 2-16

Familial Circumstances by Nature of Case

Circumstances	Serial Abuse Cases				Isolated Incident Cases			
	Present		Absent		Present		Absent	
Parents Evidence Intellectual Inadequacies	28	26.7	36	34.3	31	24.2	35	27.3
Mother Shows Evidence of Sexual Promiscuity and/or Drug or Alcohol Abuse	65	61.3	18	17.0	50	39.1	38	29.7
Parents Evidence Emotional/Psychological Problems	71	67.0	8	7.5	76	59.4	10	7.8
Father Shows Evidence of Sexual Promiscuity and/or Drug or Alcohol Abuse	41	38.7	17	16.0	26	20.3	32	25.0
Parents Evidence Physical Problems/Illness	23	21.7	40	37.7	22	17.2	48	37.5
History or Evidence of Prior Physical Abuse to Child	85	80.2	16	15.1	44	36.5	51	40.5
Parents Experiencing Marital Problems	47	44.3	34	32.1	43	34.6	48	37.8
Parents Experiencing Temporary Financial Problems	56	57.8	13	12.3	37	28.9	31	24.2
Family of Low Subsistence and General Living Level	82	77.4	12	11.3	61	47.7	32	25.0
Neglect is Chronic	65	62.9	16	15.1	36	28.9	46	36.2
Mother Evidences Little Love for Child	34	34.6	33	31.7	25	20.5	55	43.3
Father Evidences Little Love for Child	21	19.8	28	26.4	20	15.6	49	38.3
Child Evidences Intellectual Inadequacies	20	18.9	43	40.6	13	10.2	67	52.3
Child Evidences Emotional/Psychological Problems	38	35.8	21	19.8	28	21.9	51	39.8
Child Evidences Behavioral Atypicalities	16	15.1	42	39.6	19	14.8	57	44.5
Child Evidences Physical Defects and/or Illnesses	18	18.1	48	45.7	20	16.5	63	49.6
Parent Single Living with Man	13	12.3	85	80.2	15	11.7	96	75.0
Parent Single Living with Woman	0	--	98	92.5	0	--	108	84.4
Too Many Children in Family for Income and/or Dwelling	48	45.3	33	31.1	23	18.0	70	54.7
Parent-Child Conflicts	19	17.9	46	43.4	17	13.3	75	58.6
Other Circumstances	47	44.3	1	0.9	27	21.1	1	0.8

TABLE 2-17

Race and Familial Circumstances by Nature of Case

Circumstances	Serial Abuse Cases								Isolated Incident Cases							
	White				Black				White				Black			
	Present		Absent		Present		Absent		Present		Absent		Present		Absent	
Parents evidence intellectual inadequacies	21	28.4	24	32.4	6	22.2	11	40.7	21	22.3	27	28.7	7	29.2	7	29.2
Mother shows evidence of sexual promiscuity and/or drug or alcohol abuse	38	51.4	15	20.3	26	92.9	1	3.6	36	38.3	30	31.9	11	45.8	4	16.7
Parents evidence emotional/psychological problems	51	68.9	5	6.8	16	57.1	3	10.7	56	59.6	8	8.5	15	62.5	1	4.2
Father shows evidence of sexual promiscuity and/or drug or alcohol abuse	34	45.9	11	14.9	5	17.9	4	14.3	22	23.4	27	28.7	4	16.7	1	4.2
Parents evidence physical problems/illness	15	20.3	26	35.1	8	28.6	12	42.9	17	18.1	37	39.4	3	12.5	9	37.5
History or evidence of prior physical abuse to child	60	81.1	10	13.5	21	75.0	6	21.4	37	39.8	38	40.9	9	37.5	8	33.3
Parents experiencing marital problems	38	51.4	19	25.7	6	21.4	15	53.6	38	40.9	32	34.4	5	20.8	10	41.7
Parents experiencing temporary financial problems	39	52.7	11	14.9	16	57.1	2	7.1	28	29.8	23	24.5	6	25.0	5	20.8
Family of low subsistence and general living level	55	74.3	12	16.2	25	89.3	0	--	39	41.5	27	28.7	18	75.0	2	8.3
Parent single living with man	6	8.1	64	86.5	7	25.0	17	60.7	9	9.6	76	80.9	4	16.7	15	62.5
Too many children in family for income and/or dwelling	26	35.1	30	40.5	20	71.4	2	7.1	18	19.1	54	57.4	4	16.7	11	45.8

40.5 percent of the white families and in only 7.1 percent of the black. For the isolated incident cases, 19.1 percent of the white and 16.7 percent of the black had too many children. In 57.4 percent of the white and 45.8 percent of the black this condition was known to be absent.

Types of Abuse and Family Circumstances

The two most prevalent family circumstances present were parents evidencing emotional/psychological problems and the family being at a low subsistence level. It was reported earlier that the most frequently reported types of abuse in both types of cases were physical abuse unrelated to disciplinary measures, neglect due to parental inadequacies, and abandonment. Without controlling for race and the nature of the case, we undertook elementary analyses of types of abuse in relation to family circumstances.

One notes in Table 2-18 a distinct clustering pattern of circumstances in terms of the form of abuse. Where abandonment was the abusive problem, the low level of living, the sexual, drug, and/or alcohol consumptive behavior of the female parent/substitute, and parental emotional/psychological problems were, in that order, the most common familial circumstances. These same circumstances, the rank ordering different however, were the most frequently observed in cases involving physical abuse which was unrelated to discipline. Regarding physical abuse which was related to disciplinary measures, history of abuse to the child and parental emotional/psychological problems were the two most common circumstances, with low living level and child's atypical behavior both being the third.

We observed that the ordering of circumstances differed for neglect cases. The emotional/psychological problems of parents was only ranked high among such cases in which the neglect was determined to result from parental inadequacies. Among the cases involving neglect due to parent's absence, low level of living, sexual-alcohol-drug behavior of the female parent, and chronic neglect were the most frequently observed circumstances. In neglect cases in which both child and parent were home, low living level and mother's behavior were the first and second most common condition. Parent's emotional/psychological problems, temporary financial problems, and history of abuse to child were all third in order of frequency. For the cases involving emotional abuse, the most common family circumstance was parent's emotional/psychological problems, with history of abuse being the second. Mother's behavior and marital problems were both ranked third in frequency.

Seriousness of Harm and Family Circumstances

Among both the serial abuse and the isolated incident cases, child related problems or conditions were among the most likely circumstance to be present in cases in which the harm was serious. Among both types of cases, harm was of a serious nature in over sixty percent of the cases in which the child had physical problems. In well over forty percent of the cases in which parent(s) evidenced intellectual problems, the harm suffered by the child was serious.

In the isolated incident caseload, the child's problems in intellectual functioning and the mother living with a man were also prevalent circumstance among serious cases.

While low level of living was a circumstance present for a significant number of families in both types of cases, the family financial situation was not over-represented by serious cases. See Table 2-19 for the complete distribution.

Children and Families Served in the PSU Savannah, Chatham County, Georgia

Age, Sex and Race

There were 259 cases in the PSU caseload. Of these, 51.3 percent of the children were less than six years of age, 32.8 percent less than three, and 18.5 percent less than one. At the other end of the age distribution, 27.7 percent of the children were ten years and older, with 12.3 percent being fourteen and above. The complete age distribution is presented in Table 2-20.

Noted also in Table 2-20 are the differences in the age distribution by the nature of the case. In general, children in the serial abuse caseload were older than those in the isolated incident caseload. Among the serial abuse cases, 42.2 percent were less than six years old; 25.0 percent were in the three to less than six age range; 17.2 percent were less than three; and only 4.7 percent were under the age of one. Among isolated incident cases, 54.4 percent were less than age six, with 38.0 percent being under the age of three and a high of 23.1 percent under one; 16.4 percent were in the three to less than six age category.

Children age ten and above accounted for 32.8 percent of those among serial abuse cases and for 26.2 percent of those on whom only one report had been made.

TABLE 2-18

Rank Ordered Family Circumstances by Type of Abuse

Type Abuse	Order of Circumstance
Abandonment	8, 3, 2
Abuse-discipline related	5, 2, 8-12
Abuse-unrelated to discipline	2, 3-5, 8
Emotional abuse	2, 5, 3-6
Neglect-parent(s) absent	8, 3, 9
Neglect-parent/child home	8, 3, 2-7-5
Neglect-parental inadequacies	2, 8, 3-5
Sexual abuse	2-11, 6, 4
Abuse-motive undetermined	8, 2-5, 9

	Circumstance
1.	Parental intellectual problems
2.	Parental emotional/psychological problems
3.	Mother(s) behavior-sexual, drug, alcohol
4.	Father(s) behavior-sexual, drug, alcohol
5.	History of abuse to child
6.	Marital problems
7.	Temporary financial problems
8.	Low living level
9.	Chronic neglect
10.	Child's intellectual problems
11.	Child's emotional/psychological problems
12.	Child's atypical behaviors

TABLE 2-19

Seriousness of Harm and Family Circumstances
by Nature of Case

Family Circumstance	Number and Percent Serious					
	Serial Abuse		Isolated Incident		Total Caseload	
Parents intellectual problems	11	45.8	18	62.1	29	54.7
Parents emotional/psychological problems	23	36.5	36	52.2	59	44.7
Mothers-sexual, drug, alcohol	16	28.6	17	38.6	33	33.3
Fathers-sexual, drug, alcohol	10	27.8	9	39.1	19	32.2
Parents physical problems	4	22.2	36	52.4	15	38.5
History of abuse	28	36.8	18	40.9	46	38.3
Marital problems	13	30.2	14	35.0	27	32.5
Temporary financial problems	12	25.5	9	28.1	21	26.6
Low subsistence level	20	27.8	28	50.9	48	37.8
Chronic neglect	18	30.0	19	55.9	37	39.4
Mother-little love for child	11	32.2	12	48.0	23	39.0
Father-little love for child	4	21.1	9	50.0	13	35.1
Child intellectual problems	5	29.4	8	72.7	13	46.4
Child emotional/psychological problems	7	21.9	11	40.7	18	30.5
Child atypical behavior	4	30.8	8	44.4	12	38.7
Child physical problems	10	62.5	13	65.0	23	63.9
Parent single living with man	2	16.7	9	69.2	11	44.0
Parent single living with woman	0	--	0	--	0	--
Too many children	13	33.8	9	45.0	22	34.4

*Percentages are based on total serious and not serious cases. Cases involving unknown degree of severity are not included.

TABLE 2-20

Age of Children by Nature of Case

Nature of Case*	Age of Children																		Total
	Under 1 Year		1 to < 2 Years		2 to < 3 Years		3 to < 6 Years		6 to < 8 Years		8 to < 10 Years		10 to < 12 Years		12 to < 14 Years		14 to < 16 Years		16 to < 18 Years		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Serial Abuse Cases	3	4.7 (6.3)	3	4.7 (13.0)	5	7.8 (35.7)	16	25.0 (33.3)	7	10.9 (24.1)	9	14.1 (36.0)	8	12.5 (38.1)	5	7.8 (26.3)	7	10.9 (33.3)	1	1.6 (9.0)	64 (24.7)
Isolated Incident Cases	45	23.1 (93.7)	20	10.3 (87.0)	9	4.6 (64.3)	32	16.4 (66.7)	22	11.3 (75.9)	16	8.2 (64.0)	13	6.7 (61.9)	14	7.2 (73.7)	14	7.2 (66.7)	10	5.1 (91.0)	195 (75.3)
Total N & %	48	18.5	23	8.9	14	5.4	48	18.5	29	11.2	25	9.7	21	8.1	19	7.3	21	8.1	11	4.2	259
Cumulative %				27.4		32.8		51.3		62.5		72.2		80.3		87.6		95.7		100.0	

Column percentages are presented in parentheses; other percentages are based on row totals.

*Throughout the report serial abuse refers to cases analysed as Deck 1 and isolated incident to those analysed as Deck 2.

Of the cases for which sex was known (N=255), 51.0 percent were females and 49.0 percent were males. It is noted in Table 2-21, however, that females were more likely to be among serial abuse cases–29.2 percent of the females and 20.8 percent of the males.

The race of children was known in 249 cases. Of these, 64.7 percent were white and 35.3 percent were black. By the nature of the case, a slightly higher percent of the black children (27.3 percent) were among the serial abuse cases. This compares to 24.2 percent of the white children. See Table 2-21.

Age and Race by Nature of Case

Data on the total caseload revealed that:

1) slightly over fifty percent of the children were less than six years old, with 32.8 percent being less than three and 18.5 percent less than one;

2) a much higher percent of children on whom one report had been made were less than three years old as compared to those among serial abuse cases; and

3) a slightly higher percent of the black children were among serial abuse cases than the percent of the white children.

Noting the age distribution by race for the total caseload, we found the tendency for white children to be younger. According to the data in Table 2-22, a higher percent of the white children were less than six years old (55.9 percent) with 36.6 percent being less than three. This compares to 44.3 and 25.0 percent of the black children for the respective age categories. Conversely, 32.9 percent of the black children as compared to 24.8 percent of the white children were age ten and above.

Among isolated incident cases, 60.7 percent of the white children were less than age six with 41.8 percent being less than three. This compares to 43.8 and 29.7 percent of the black children in these young age categories. For the older children, 22.9 percent of the white and 32.8 percent of the black children among isolated incident cases were ten years of age and above.

The age distribution for the races differed less among serial abuse cases–41.0 percent of the white children were less than six with 20.5 percent being less than three as compared to 45.8 and 12.5 percent of the black children. The difference was even less pronounced for the older age categories; 30.8 percent of the white and 33.3 percent of the black children among serial abuse cases were age ten and above.

TABLE 2-21

Sex and Race of Children by Nature of Case

Nature of Case	Sex					Race				
	Male					White		Black		
	N	%	N	%	Total	N	%	N	%	Total
Serial Abuse Cases	26	40.6 (20.8)	38	59.4 (29.2)	64	39	61.9 (24.2)	24	38.1 (27.3)	63
Isolated Incident Cases	99	51.8 (79.2)	92	48.2 (70.8)	191	122	65.6 (75.8)	64	34.4 (72.7)	186
Total	125	49.0	130	51.0	255	161	64.7	88	35.3	249

TABLE 2-22

Age and Race of Children by Nature of Case

Race	Age Level										
Serial Abuse Cases	< 3		3 < 6		6 < 10		10 < 14		14 < 18		Total
	N	%	N	%	N	%	N	%	N	%	
White	8	20.5 (72.7)	8	20.5 (50.0)	11	28.2 (68.8)	8	20.5 (61.5)	4	10.3 (57.1)	39 61.9
Black	3	12.5 (27.3)	8	33.3 (50.0)	5	20.8 (31.2)	5	20.8 (38.5)	3	12.5 (42.9)	24 38.1
Total	11	17.5	16	25.4	16	25.4	13	20.6	7	11.1	63
Isolated Incident Cases	N	%	N	%	N	%	N	%	N	%	Total
White	51	41.8 (72.9)	23	18.9 (71.9)	20	16.4 (57.1)	16	13.1 (61.5)	12	9.8 (52.2)	122 65.6
Black	19	29.7 (27.1)	9	14.1 (28.1)	15	23.4 (42.9)	10	15.6 (38.5)	11	17.2 (47.8)	64 34.4
Total	70	37.6	32	17.2	35	18.8	26	14.0	23	12.4	186
Total Caseload	N	%	N	%	N	%	N	%	N	%	Total
White	59	36.6 (72.8)	31	19.3 (64.6)	31	19.3 (60.8)	24	14.9 (61.5)	16	9.9 (53.3)	161 64.7
Black	22	25.0 (27.2)	17	19.3 (35.4)	20	22.7 (39.2)	15	17.0 (38.5)	14	15.9 (46.7)	88 35.3
Total	81	32.5	48	19.3	51	20.5	39	15.7	30	12.0	249

By age and race, which children were the most likely to be reported for repeated maltreatment? According to Table 2-23, black children age three but less than six were more likely than white children in this age range to have been victims of repeated reports of maltreatment. For all black children in this age category, 47.1 percent were among the serial abuse cases; this compares to 8 or 25.8 percent of the white children. On the other hand, white children in the six to less than ten age range were more likely to be among serial abuse cases–35.5 percent of the white and 25.0 percent of the black in this age group.

Sex and Race by Nature of Case

While there was a negligible percentage difference in the sex distribution of the total caseload, we noted that females were more likely to be among serial abuse cases than were males. A different pattern emerged when we analyzed the sex and race of the children by the nature of the case. Of a total of 81 white females in the total caseload, 26 or 32.1 percent represented serial abuse cases. This compares to 16.5 percent of the 79 white males. The percent of black females among serial abuse cases was 24.4 as compared to 31.0 percent of the black males. Thus, it appears that white females and black males were more likely than were white males and black females to be in the serial abuse caseload. See Table 2-24 for these findings.

Age, Sex, and Race by Nature of Case

According to Table 2-25, a slightly higher percent of the white males in the total caseload were under the age of three (36.8 percent) than the percent of white females (31.6 percent). On the other hand, a higher percent of the white females were in the older age groupings than the percent of the white males–17.7 percent females to 2.6 percent males were age fourteen and above. Noting the data by the nature of the case, however, we found some variation from this pattern. Among serial abuse cases, 23.1 percent of the females as compared to 15.4 percent of the males were less than three years of age, while none of the white males and 15.3 percent of the white females were fourteen and above. Among isolated incident cases, a higher percent of the males were less than three years old–41.2 percent males to 35.9 percent of the females. Again, a higher percent of the females were age fourteen and above–18.8 percent to 3.2 percent male.

The pattern observed for white children was not present for the black children in the total caseload; 27.9 percent of the females as compared to 16.7 percent of the males were less than three years of age. Further, there was little difference in the total caseload between the percent males and females reported in the age category of fourteen and above–14.3 and 18.6 percent, respectively. There was a tendency for black females to be younger than the males in both types

TABLE 2-23

Percent of Children Among Serial Abuse Cases by Age and Race*

Race	Age of Children										Total
	< 3 Years		3 < 6 Years		6 < 10 Years		10 < 14 Years		14 < 18 Years		
	N	%	N	%	N	%	N	%	N	%	
White	8	13.6	8	25.8	11	35.5	8	33.3	4	25.0	39
Black	4	13.6	8	47.1	5	25.0	5	33.3	3	21.4	24
Total	11	13.6	16	33.3	16	31.4	13	33.3	7	23.3	63

*The numbers for age levels are Deck 1 (serial abuse caseload) data found in Table 2-22. Percentages are based on the number of Deck 1 children in each age category as a percent of the total number of children in each age category.

TABLE 2-24

Sex and Race of Children by Nature of Case

Race	Sex of Children											
	Serial Abuse				Isolated Incident				Total Caseload			
	Male		Female		Male		Female		Male		Female	
	N	%	N	%	N	%	N	%	N	%	N	%
White	13	33.3 (50.0)	26	66.7 (70.3)	66	54.5 (69.5)	55	45.5 (61.8)	79	49.4 (65.3)	81	50.6 (64.3)
Black	13	54.2 (50.0)	11	45.8 (29.7)	29	46.0 (30.5)	34	54.0 (38.2)	42	48.3 (34.7)	45	51.7 (35.7)
Total	26	41.3	37	58.7	95	51.6	89	48.4	121	49.0	126	51.0

of cases. Among serial abuse cases, only 7.7 percent of the black males as compared to 18.2 percent of the females were less than three years of age. Unexpectedly, 15.4 percent of the males as compared to 9.1 percent of the females were age fourteen and above. Similarly, 20.7 percent of the males and 31.3 percent of the females on whom only one report had been made (isolated incident cases) were less than three years old. At the upper end of the age distribution for isolated incident cases, 21.9 percent of the black females and 13.8 percent of the males were fourteen and above. Due to the small numbers on which the percentages for black children are based, these findings should be interpreted with caution.

Types of Abuse Reported

Neglect due to parental inadequacies was by far the most prevalent type of abuse for both the children who had been previously reported and those on whom only one report was made. Among serial abuse cases, physical abuse determined not to be related to disciplinary action and emotional abuse were the second and third most frequently reported types. For the children among isolated incident cases, abandonment rather than emotional abuse surfaced as the third type.

When we noted the types of abuse by race and the nature of the case, variations were observed in the ordering. Neglect resulting from parental inadequacies remained the most prevalent form of abusive treatment for both black and white children among both types of cases. For white children among serial abuse cases, physical abuse unrelated to discipline and emotional abuse remained the most frequently reported forms of maltreatment. For black children, the three most prevalent forms were all the variations of neglectful conditions; namely, due to parental inadequacies, willful neglect with parent and child being home, and neglect of child resulting from parental absence.

Among isolated incident cases the distribution was the same for white and black children. Abandonment and physical abuse determined to be unrelated to disciplinary measures were the second and third most frequently reported types of abuse. See Table 2-26 for the complete distribution.

Seriousness of Harm Suffered

Maltreatment resulted in serious harm, including one fatality, to approximately one-fourth of the children in the total caseload. A slightly higher percent of the children among serial abuse cases were seriously harmed (28.1 percent) than were those among isolated incident cases (24.1 percent).

Similarly, a slightly higher percent of the children among the serial abuse cases were known to have been seen by a physician and to have been hospitalized. These data are reported in Table 2-27.

In regard to seriousness of harm by race we found no differences in the total caseload between the percent of

TABLE 2-25

Age, Race, and Sex of Children by Nature of Case

Age	Race and Sex of Children															
	White								Black							
	Total Caseload				Serial Abuse				Isolated Incident				Total Caseload				Serial Abuse				Isolated Incident			
	Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
< 1 year	13	54.2 (17.1)	11	45.8 (13.9)	0	--	2	100.0 (7.7)	13	59.1 (20.5)	9	40.9 (17.0)	5	41.7 (11.9)	7	58.3 (16.3)	1	100.0 (7.7)	0	--	4	36.4 (13.8)	7	63.6 (21.9)
1 < 2	9	45.0 (11.8)	11	55.0 (13.9)	0	--	2	100.0 (7.7)	9	50.0 (14.3)	9	50.0 (17.0)	2	66.7 (4.8)	1	33.3 (2.3)	0	--	1	100.0 (9.1)	2	100.0 (6.9)	0	--
2 < 3	6	66.7 (7.9)	3	33.3 (3.8)	2	50.0 (15.4)	2	50.0 (7.7)	4	80.0 (6.3)	1	20.0 (1.9)	0	--	4	100.0 (9.3)	0	--	1	100.0 (9.1)	0	--	3	100.0 (9.4)
3 < 6	21	67.7 (27.6)	10	32.3 (12.7)	4	50.0 (30.8)	4	50.0 (15.4)	17	73.9 (27.0)	6	26.1 (11.3)	11	64.7 (26.2)	6	35.3 (14.0)	5	62.5 (38.5)	3	37.5 (27.3)	6	66.7 (20.7)	3	33.3 (9.4)
6 < 8	11	61.1 (14.5)	7	38.9 (8.9)	2	40.0 (15.4)	3	60.0 (11.5)	9	69.2 (14.3)	4	30.8 (7.5)	6	66.7 (14.3)	3	33.3 (7.0)	1	50.0 (7.7)	1	50.0 (9.1)	5	71.4 (17.2)	2	28.6 (6.2)
8 < 10	4	30.8 (5.3)	9	69.2 (11.4)	2	33.3 (15.4)	4	66.7 (15.4)	2	28.6 (3.2)	5	71.4 (9.4)	7	63.6 (16.7)	4	36.4 (9.3)	2	66.7 (15.4)	1	33.3 (9.1)	5	62.5 (17.2)	3	37.5 (9.4)
10 < 12	7	53.8 (9.2)	6	46.2 (7.6)	3	42.9 (23.1)	4	57.1 (15.4)	4	66.7 (6.3)	2	33.3 (3.8)	2	28.6 (4.8)	5	71.4 (11.6)	1	100.0 (7.7)	0	--	1	16.7 (3.4)	5	83.3 (15.6)
12 < 14	3	27.3 (3.9)	8	72.7 (10.1)	0	--	1	100.0 (3.8)	3	30.0 (4.8)	7	70.0 (13.2)	3	37.5 (7.1)	5	62.5 (11.6)	1	25.0 (7.7)	3	75.0 (27.3)	2	50.0 (6.9)	2	50.0 (6.2)
14 < 16	1	11.1 (1.3)	8	88.9 (10.1)	0	--	3	100.0 (11.5)	1	16.7 (1.6)	5	83.3 (9.4)	6	46.2 (14.3)	7	53.8 (16.3)	2	66.7 (15.4)	1	33.3 (9.1)	4	40.0 (13.8)	6	60.0 (18.8)
16 < 18	1	14.3 (1.3)	6	85.7 (7.6)	0	--	1	100.0 (3.8)	1	16.7 (1.6)	5	83.3 (9.4)	0	--	1	100.0 (2.3)	0	--	0	--	0	--	1	100.0 (3.1)
Total	76	49.0	79	51.0	13	33.3	26	66.7	63	54.3	53	45.7	42	49.4	43	50.6	13	54.2	11	45.8	29	47.5	32	52.5

TABLE 2-26

Types of Abuse by Nature of Case

Race	Types of Abuse																			
	Abandonment		Physical Abuse/ Discipline Related		Physical Abuse Unrelated to Discipline		Emotional Abuse		Neglect Child home/ Parent Absent		Neglect Parent-Child Home		Neglect Parental Inadequacies		Sexual Abuse		Physical Abuse Motive Undetermined		Other	
Serial Abuse	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	3	5.8	2	3.8	11	21.2	8	15.4	3	5.8	4	7.7	17	32.7	1	1.9	1	1.9	2	3.8
Black	3	8.6	1	2.9	2	5.7	4	11.4	5	14.3	6	17.1	9	25.7	0	---	3	8.6	2	5.7
Isolated Incident	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	18	12.0	16	10.7	18	12.0	12	8.0	8	5.4	6	4.0	46	30.9	9	6.0	3	2.0	13	8.7
Black	10	13.3	3	4.0	8	10.7	5	6.6	2	2.7	4	5.3	31	41.3	3	4.0	2	2.7	7	9.3
Total Caseload	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	21	10.4	18	9.0	29	14.4	20	10.0	11	5.5	10	5.0	63	31.3	10	5.0	4	2.0	15	7.5
Black	13	11.8	4	3.6	10	9.0	9	8.2	7	6.4	10	9.0	40	36.4	3	2.7	5	4.5	9	8.2

Percentages are based on number of children. Percentages do not add up to 100 since some children sustained more than one form of maltreatment.

TABLE 2-27

Seriousness of Harm by Nature of Case

Nature of Case (Deck No.)	Seriousness							Physician Seen?							Hospitalized?						
	Not Serious		Serious		Unknown		Total	Yes		No		Unknown		Total	Yes		No		Unknown		Total
	N	%	N	%	N	%		N	%	N	%	N	%		N	%	N	%	N	%	
Deck 1 (Serial Abuse)	41	64.1 (23.2)	18	28.1 (27.7)	5	7.8 (29.4)	64 24.7	15	23.4 (28.8)	34	53.1 (20.5)	15	23.4 (37.5)	64	7	10.9 (29.2)	41	64.1 (22.0)	16	25.0 (33.3)	64
Deck 2 (Isolated Incident)	136	69.7 (76.8)	47*	24.1 (72.3)	12	6.2 (70.6)	195 72.3	37	19.1 (71.2)	132	68.0 (79.5)	25	12.9 (62.5)	194	17	8.8 (70.8)	145	74.7 (78.0)	32	16.5 (66.7)	194
Total	177	68.3	65	25.1	17	6.6	259	52	20.2	166	64.3	40	15.5	258	24	9.3	186	72.1	48	18.6	258

*Includes one (1) fatal case.

white and black children who were seriously harmed. In considering the nature of the case, however, we observed that while a higher percent of both white and black children were seriously harmed in the serial abuse caseload than in the caseload of isolated incident cases, the difference between the two levels of severity among the two types of cases was more pronounced for the white children. Among serial abuse cases, 32.4 percent of the white children were seriously harmed; this compares to 25.4 percent among isolated incident cases. On the other hand, 28.6 percent of the black children among serial abuse cases and 26.7 percent among the isolated incident cases were seriously harmed.

Seriousness of harm by age and race of children is presented in Table 2-28. Of the total caseload, 41 or 27.2 percent of the white children suffered serious harm, with 48.8 percent of the seriously harmed being less than six years of age and 24.4 percent less than three. There were 36.6 percent of the seriously harmed white children who were ten years and older.

While a higher percent of serial abuse cases involving white children were serious in nature, a higher percent of the seriously harmed among isolated incident cases were less than six years of age (55.1 percent) as compared to those among the serial abuse cases (33.3 percent). For the older children, those who were reported for repeated abusive treatment were more likely than those among isolated incident cases to have been seriously harmed. Only 34.4 percent of the serious isolated incident cases as compared to 41.7 percent of the serious serial abuse cases involved children who were ten years and older.

Of the black children in the total caseload, 27.2 percent were seriously harmed, including one fatality, with 59.1 percent being less than age six and 31.8 percent being less than three. Slightly less than thirty percent (27.2) of the black children who were seriously harmed were ten years and older.

Thus, it appears that in noting the total caseload without consideration of the nature of the case, a higher percent of the black children who were seriously harmed were in the youngest age categories while a higher percent of the white children were in the older age categories.

The age distribution of serious cases involving black children by the nature of the case differed from that involving white children. While there was little difference in the percent of black and white children among serial abuse cases under the age of six, black children of this age range were more likely to be seriously harmed--4 or 25.0 percent of the 16 white children under six as compared to 5 or 55.6 percent of the 9 black children were seriously harmed. Succinctly, 33.3 percent of the white children and 83.3 percent of the black children in the serial abuse caseload, who were seriously harmed, were less than six years of age. In regard to older children among serial abuse cases, none of the black children age ten and above as compared to 41.7 percent of the white were seriously harmed.

Among isolated incident cases, a higher percent of the white children were less than six years old, 60.5 percent to 43.3 percent of the black children. Of the 69 white children under age six among isolated incident cases, 16 or 23.2 percent were seriously harmed. This compares to 8 or 30.8 percent of the 26 black children under six. On the other hand, white children age ten and above were more likely to be seriously harmed. Ten or 40.0 percent of these older white children were seriously harmed in comparison to 6 or 30.0 percent of the older black children.

Synthesizing these findings regarding seriousness of harm by age, race, and nature of the case:

1) in general, white children were more likely to be less than six years old;

2) a higher percent of all white children were seriously harmed;

3) black children who were seriously harmed were more likely to be less than age six while a higher percent of the white children were ten years and above.

Regarding seriousness of harm by race and sex, there was no difference between the percent of white males and females who were seriously harmed in the total caseload. When considering the types of cases, however, we found that males among serial abuse cases were more likely (46.2 percent) than were females (25.0 percent) to be seriously harmed. On the other hand, the situation was reversed for the isolated incident cases--28.3 percent females and 23.3 percent males were seriously harmed.

For black children in the total caseload, 31.7 percent of the females and 20.5 percent of the males were seriously harmed. Among serial abuse cases, however, the reverse was observed--36.4 percent of the males and 20.0 percent of the

TABLE 2-28

Seriousness of Harm by Age, Race, and Nature of Case

Age	Deck 1 (Serial Abuse) Not Serious		Deck 1 (Serial Abuse) Serious		Deck 1 (Serial Abuse) Total	Deck 2 (Isolated Incident) Not Serious		Deck 2 (Isolated Incident) Serious		Deck 2 (Isolated Incident) Total	Total Caseload Not Serious		Total Caseload Serious		Total Caseload Total
Seriousness - White Children															
< 3	7	87.5 (28.0)	1	12.5 (8.3)	8	37	80.4 (43.5)	9	19.6 (31.0)	46	44	81.5 (40.0)	10	18.5 (24.4)	54
3 < 6	5	62.5 (20.0)	3	37.5 (25.0)	8	16	69.6 (18.8)	7	30.4 (24.1)	23	21	67.7 (19.1)	10	32.3 (24.4)	31
6 < 10	6	66.7 (24.0)	3	33.3 (25.0)	9	17	85.0 (20.0)	3	15.0 (10.3)	20	23	79.3 (20.9)	6	20.7 (14.6)	29
10 < 14	6	75.0 (24.0)	2	25.0 (16.7)	8	10	66.7 (11.8)	5	33.3 (17.2)	15	16	69.6 (14.5)	7	30.4 (17.1)	23
14 < 18	1	25.0 (4.0)	3	75.0 (25.0)	4	5	50.0 (5.9)	5	50.0 (17.2)	10	6	42.9 (5.5)	8	57.1 (19.5)	14
Total	25	67.6	12	32.4	37	85	74.6	29	25.4	114	110	72.8	41	27.2	151
Seriousness - Black Children															
< 3	1	33.3 (6.7)	2	66.7 (33.3)	3	12	70.6 (27.3)	5	29.4 (31.3)	17	13	65.0 (22.0)	7	35.0 (31.8)	20
3 < 6	3	50.0 (20.0)	3	50.0 (50.0)	6	6	66.7 (13.6)	3	33.3 (18.8)	9	9	60.0 (15.3)	6	40.0 (27.3)	15
6 < 10	4	80.0 (26.7)	1	20.0 (16.7)	5	12	85.7 (27.3)	2	14.3 (12.5)	14	16	84.2 (27.1)	3	15.8 (13.6)	19
10 < 14	4	100.0 (26.7)	0	--	4	6	66.7 (13.6)	3	33.3 (18.8)	9	10	76.9 (16.9)	3	23.1 (13.6)	13
14 < 18	3	100.0 (20.0)	0	--	3	8	72.7 (18.2)	3	27.3 (18.8)	11	11	78.6 (18.6)	3	21.4 (13.6)	14
Total	15	71.4	6	28.6	21	44	73.3	16	26.7	60	59	72.8	22	27.2	81

Table does not include unknowns.

females were seriously harmed. On the other hand, 35.5 percent of the females and 14.3 percent of the males among the isolated incident cases were seriously harmed.

The above findings are noted in Table 2-29. Some intriguing aspects can be pointed out:

1) white males represented slightly more than one-third of the serial abuse cases for all white children but were involved in 50.0 percent of the serious cases;

2) white males among the isolated incident cases accounted for over fifty percent of the cases but slightly less than fifty percent of those determined to be serious in nature;

3) black males represented 52.4 percent of the serial abuse cases for all black children and were involved in two-thirds of the serious cases;

4) black males, among the isolated incident cases accounted for 47.5 percent of the caseload but only 26.7 percent of the serious cases;

5) in the total caseload, black females were most likely to be seriously harmed, while black males were least likely.

Prior Reported Abuse of Children

Of a total of 259 cases, 64 or 24.7 percent represented cases on which at least one incident prior to the most current had been reported to the Savannah Protective Service Unit (PSU); 195 or 75.3 percent were isolated--single reported--incident cases.*

According to Table 2-30, 44 or 68.8 percent of the serial abuse cases had only one known prior report; 11 or 17.1 percent had two prior reports; 6 or 9.4 percent had three; and 3 or 4.7 percent had four or more.

While females were more likely to be victims of repeated reports; i.e., females represented approximately three-fifths of the serial abuse cases, males were more likely to be reported more often. Slightly less than three-fourths (74.4 percent) of the females to 61.5 percent of the males had only one prior report. Approximately twenty percent of the males and ten percent of the females had been reported three or more times prior to the most current reported incident.

It was determined earlier that a slightly higher percent of the black children were among serial abuse cases than the percent of white children. Accordingly to Table 2-31, however, a slightly higher percent of the black children had only one prior report--70.8 percent in comparison to 67.5 percent of the white children. Similarly, a higher percent of the white children had three or more prior reported incidents.

Concerning age, we noted that the children within the age category of ten to less than fourteen were reported more often than were the children in any other age grouping, with those six to less than ten being next. Slightly over fifty percent of both groups of children had two or more prior reports in comparison to twenty-five percent or less for the other age categories. See Table 2-32 for the complete distribution.

Prior Placement of Children

Eighteen or 28.1 percent of the 64 children in the serial abuse caseload had at least one known prior placement. Fifteen or 83.3 percent of these eighteen children had only one prior placement. One child had been placed out of the home four times.

Of the children having been in placement, ten or 55.6 percent were female. Of all the females (N=38) among the serial abuse cases, those having previously been in placement (N=10) represent 26.3 percent. By comparison, 8 or 30.8 percent of the males had been in placement (N=26).

With respect to race, 12 or 66.7 percent of the known prior placements were of white children. Similarly, a higher percent of the white children in the serial abuse caseload had a placement history (30.0 percent based on an N of 40) as compared to the percent of the black children (25.0 percent based on an N of 24).

Regarding age and prior placement of children among serial abuse cases, the children age ten to less than fourteen accounted for 7 or 38.9 percent of those with a placement history, and those six to less than ten accounted for 4 or

*Perhaps it would be more accurate to refer to the prior investigation of reported abuse rather than prior reported abuse. As reported in our earlier work, personnel in the PSU indicated that some reported cases were simply not investigated.

TABLE 2-29

Seriousness of Harm by Race, Sex, and Nature of Case

Seriousness	Deck 1 (Serial Abuse) Male N	Male %	Female N	Female %	Total	Deck 2 (Isolated Incident) Male N	Male %	Female N	Female %	Total	Total Caseload Male N	Male %	Female N	Female %	Total
Sex of White Children															
Not Serious	7	28.0 (53.8)	18	72.0 (75.0)	25	46	54.8 (76.7)	38	45.2 (71.7)	84	53	48.6 (72.6)	56	51.4 (72.7)	109
Serious	6	50.0 (46.2)	6	50.0 (25.0)	12	14	48.3 (23.3)	15	51.7 (28.3)	29	20	48.8 (27.4)	21	51.2 (27.3)	41
Total	13	35.1	24	64.9	37	60	53.1	53	46.9	113	73	48.7	77	51.3	150
Sex of Black Children															
Not Serious	7	46.7 (63.6)	8	53.3 (80.0)	15	24	54.5 (85.7)	20	45.5 (64.5)	44	31	52.5 (79.5)	28	47.5 (68.3)	59
Serious	4	66.7 (36.4)	2	33.3 (20.0)	6	4	26.7 (14.3)	11	73.3 (35.5)	15	8	38.1 (20.5)	13	61.9 (31.7)	21
Total	11	52.4	10	47.6	21	28	47.5	31	52.5	59	39	48.8	41	51.2	80

TABLE 2-30

Sex and Prior Reported Incidents

	Number of Prior Reported Incidents								
	1		2		3		4 or More		
Sex	N	%	N	%	N	%	N	%	Total
Male	16	61.5 (36.4)	5	19.2 (45.5)	4	15.4 (66.7)	1	3.8 (33.3)	26 40.6
Female	28	73.7 (63.6)	6	15.8 (54.5)	2	5.2 (33.3)	2	5.2 (66.7)	38 59.4
Total	44	68.8	11	17.2	6	9.4	3	4.7	64

TABLE 2-31

Race and Prior Reported Incidents

	Number of Prior Reported Incidents								
	1		2		3		4 or More		
Race	N	%	N	%	N	%	N	%	Total
White	27	67.5 (61.4)	7	17.5 (63.6)	3	7.5 (50.0)	3	7.5 (100.0)	40 62.5
Black	17	70.8 (38.6)	4	16.7 (36.4)	3	12.5 (50.0)	0	—	24 37.5
Total	44	68.8	11	17.2	6	9.4	3	4.7	64

TABLE 2-32

Age and Prior Reported Incidents

	Number of Prior Reported Incidents								
	1		2		3		4 or More		
Age	N	%	N	%	N	%	N	%	Total
< 3	9	81.8 (20.5)	2	18.2 (18.2)	0	—	0	—	11 17.2
3 < 6	13	81.2 (29.5)	2	12.5 (18.2)	1	6.3 (16.7)	0	—	16 25.0
6 < 10	9	56.3 (20.5)	4	25.0 (36.4)	2	12.5 (33.3)	1	6.2 (33.3)	16 25.0
10 < 14	7	53.8 (15.9)	3	23.1 (27.2)	1	7.7 (16.7)	2	15.4 (66.7)	13 20 3
14 < 18	6	75.0 (13.6)	0	—	2	25.0 (33.3)	0	—	8 12.5
Total	44	68.8	11	17.2	6	9.4	3	4.7	64

22.2 percent. These same aged children were more likely to have prior reports. For all the children age ten to less than fourteen among the serial abuse cases (N=13) the 7 with a placement history represent 53.8 percent. The children age six to less than ten with a placement history represent 25.0 percent of all the children in that age category among the serial abuse cases. Over thirty-five percent of the eight children age fourteen and above had a placement history.

Relationship of the Main Perpetrator

Mothers or mother substitutes were the main perpetrator in well over seventy percent of the cases. Fathers or father substitutes were the main perpetrator in slightly more than twenty percent of the cases. As co-perpetrator, fathers or father substitutes accounted for over sixty percent in comparison to less than twenty-five percent mothers or mother substitutes.

According to Table 2-33, black mothers or mother substitutes were more likely than were white mothers or mother substitutes to be identified as the main perpetrator. In the total caseload, black mothers or mother substitutes were the main perpetrator in 84.1 percent of the cases, while white mothers or mother substitutes were the main perpetrator in 68.9 percent. Black fathers or father substitutes were the main perpetrator in 10.2 percent of the cases as compared to 26.7 percent for white fathers or father substitutes.

White fathers or father substitutes were more likely than black fathers or father substitutes and black or white mothers or mother substitutes to be the main perpetrator in cases involving serious harm to children. Of the cases in which white fathers or father substitutes were involved (N=43), 20 or 46.5 percent were serious in nature. This compares to 22.2 percent (N=9) for black fathers or father substitutes, and 18.0 and 24.3 percent for white and black mother substitutes, respectively. See Table 2-34 for the complete distribution by race and nature of the case.

Family Circumstances

This section will be devoted to a brief discussion of selected circumstances with special emphasis given to differences noted in the familial circumstances and/or living conditions of the children and their families who had previously been reported and those who had not been reported prior to the current incident. Where relevant, reference is made to racial differences. The complete percentage distribution of circumstances is presented in Tables 2-35 and 2-36.

Parents Evidence Intellectual Inadequacies.–There were limited data on parental problems in intellectual functioning. Such data were unknown in nearly forty percent of the serial abuse cases and in slightly less than sixty percent of the isolated incident cases. Of the known data, slightly less than thirty percent (29.7) of the parents of children who had been reported on prior incidents and 16.5 percent of the parents of children on whom only the current report existed evidenced problems in intellectual functioning. Such problems were determined to be absent in 35.9 percent of the serial abuse cases and in 25.0 percent of the isolated incident cases.

A higher percent of the white and black parents among the serial abuse cases were determined to have problems in intellectual functioning–25.6 percent white and 37.5 percent black–than the percent of those among isolated incident cases--12.3 percent white and 25.0 percent black.

Mother Shows Evidence of Sexual Promiscuity and/or Drug or Alcohol Abuse.–Mothers of children who were victims of repeated reported abuse were more likely than mothers of children on whom only one report was made to exhibit these kinds of behaviors or problems. From the known data, such problems in mother/mother substitute behavior were present in 58.7 percent and absent in 19.0 percent among serial abuse cases. Among isolated incident cases, problem of this nature were present in 37.9 percent of the cases and absent in 24.1 percent.

Black mothers among serial abuse cases were the most likely group to exhibit such behaviors; i.e., determined to be present in 82.6 percent in comparison to 46.2 percent of the white mothers among serial abuse cases. There was no difference between the percent of black mothers (37.5) and that of white mothers (37.7 percent) who were characterized by such problems among isolated incident cases.

Parents Evidence Emotional/Psychological Problems.–These data were known in 87.5 percent of the serial abuse cases and in 73.3 percent of the isolated incident cases. A high percent of the parents for both types of cases were determined to have emotional/psychological problems--present in 73.4 percent of the serial abuse cases and in 59.5 percent of the isolated incident cases. White parents among serial abuse cases were the most likely group to have emotional/psychological problems--the characteristic was present in just under eighty percent in comparison to 62.5 percent of the black parents and 60.7 percent white and 57.8 percent black parents among isolated incident cases.

TABLE 2-33

Relationship of the Main Perpetrator by Race and Nature of Case

Race of Perpetrator	Mother/ Mother Substitute N	%	Father/ Father Substitute N	%	Other Relative N	%	No Relationship N	%	Total
	Perpetrator - Serial Abuse Cases								
White	28	71.8 (57.1)	8	20.5 (80.0)	2	5.1 (66.7)	1	2.6 (100.0)	39
Black	21	87.5 (42.9)	2	8.3 (20.0)	1	4.2 (33.3)	0	--	24
Total	49	77.8	10	15.9	3	4.8	1	1.6	63
	Perpetrator - Isolated Incident Cases								
White	83	68.0 (61.0)	35	28.7 (83.3)	0	--	4	3.3 (80.0)	122
Black	53	82.8 (39.0)	7	10.9 (16.4)	3	4.7 (100.0)	1	1.6 (20.0)	64
Total	136	73.1	42	22.6	3	1.6	5	2.7	186
	Perpetrator - Total Caseload								
White	111	68.9 (60.0)	43	26.7 (82.7)	2	1.2 (33.3)	5	3.1 (83.3)	161
Black	74	84.1 (40.0)	9	10.2 (17.3)	4	4.5 (66.7)	1	1.1 (16.7)	88
Total	185	74.3	52	20.9	6	2.4	6	2.4	249

TABLE 2-34

Seriousness of Harm by Relationship of Perpetrator, Race, and Nature of Case

Relationship of Perpetrator	Seriousness of Harm - White Children																	
	Serial Abuse Cases						Isolated Incident Cases						Total Caseload					
	Not Serious		Serious		Unknown		Not Serious		Serious		Unknown		Not Serious		Serious		Unknown	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Mother/Mother Substitute	21	75.0 (84.0)	5	17.9 (41.7)	2	7.1 (100.0)	61	73.5 (71.8)	15	18.1 (51.7)	7	8.4 (87.5)	82	73.9 (74.5)	20	18.0 (48.8)	9	8.1 (90.0)
Father/Father Substitute	2	25.0 (8.0)	6	75.0 (50.0)	0	--	20	57.1 (23.5)	14	40.0 (48.3)	1	2.9 (12.5)	22	51.2 (20.0)	20	46.5 (48.8)	1	2.3 (10.0)
Other Relative	1	50.0 (4.0)	1	50.0 (8.3)	0	--	0	--	0	--	0	--	1	50.0 (0.9)	1	50.0 (2.4)	0	--
No Relationship	1	100.0 (4.0)	0	--	0	--	4	100.0 (4.7)	0	--	0	--	5	100.0 (4.5)	0	--	0	--
Total	25	64.1	12	30.8	2	5.1	85	69.6	29	28.8	8	6.6	110	68.3	41	25.5	10	6.2
	Seriousness of Harm - Black Children																	
Mother/Mother Substitute	13	61.9 (86.7)	5	23.8 (83.3)	3	14.3 (100.0)	38	71.7 (86.4)	13*	24.5 (81.3)	2	3.8 (50.0)	51	68.9 (86.4)	18	24.3 (81.8)	5	6.8 (71.4)
Father/Father Substitute	1	50.0 (6.7)	1	50.0 (16.7)	0	--	5	71.4 (11.4)	1	14.3 (6.2)	1	14.3 (25.0)	6	66.7 (10.2)	2	22.2 (9.1)	1	11.1 (14.3)
Other Relative	1	100.0 (6.7)	0	--	0	--	1	33.3 (2.2)	1	33.3 (6.2)	1	33.3 (25.0)	2	50.0 (3.4)	1	25.0 (4.5)	1	25.0 (14.3)
No Relationship	0	--	0	--	0	--	0	--	1	100.0 (6.2)	0	--	0	--	1	100.0 (4.5)	0	--
Total	15	62.5	6	25.0	3	12.5	44	68.8	16	25.0	4	6.2	59	67.0	22	25.0	7	8.0

*Includes one (1) fatal case.

TABLE 2-35

Familial Circumstances by Nature of Case

Circumstances	Serial Abuse Cases				Isolated Incident Cases			
	Present		Absent		Present		Absent	
Parents evidence intellectual inadequacies	19	29.7	23	35.9	32	16.5	50	25.6
Mother shows evidence of sexual promiscuity and/or drug or alcohol abuse	37	58.7	12	19.0	74	37.9	47	24.1
Parents evidence emotional/psychological problems	47	73.4	9	14.1	116	59.5	27	13.8
Father shows evidence of sexual promiscuity and/or drug or alcohol abuse	15	23.4	12	18.8	50	25.6	30	15.4
Parents evidence physical problems/illness	21	33.3	19	30.2	32	16.5	57	29.4
History or evidence of prior physical abuse to child	47	74.6	14	22.2	42	21.8	70	36.3
Parents experiencing marital problems	22	45.3	22	34.4	80	41.0	40	20.5
Parents experiencing temporary financial problems	32	50.0	12	18.8	91	46.7	43	22.1
Family of low subsistence and general living level	46	71.9	9	14.1	93	47.7	46	23.6
Neglect is chronic	40	62.5	11	17.2	47	24.1	80	41.0
Mother evidences little love for child	10	15.6	31	48.4	33	16.9	89	45.[illegible]
Father evidences little love for child	7	10.9	15	23.4	20	10.3	60	30.9
Child evidences intellectual inadequacies	18	28.1	26	40.6	20	10.3	77	39.5
Child evidences emotional/psychological problems	22	34.4	20	31.3	55	28.2	57	29.2
Child evidences behavioral atypicalities	23	35.9	19	29.7	46	23.6	66	33.8
Child evidences physical defects and/or illness	16	25.0	28	43.8	26	13.3	81	41.5
Parent single living with man	7	10.9	53	82.8	10	5.1	159	81.5
Parent single living with woman	2	3.1	55	85.9	1	0.5	170	87.2
Too many children in family for income and/or dwelling	19	29.7	19	29.7	33	17.0	86	44.3
Parent-child conflict	16	25.0	36	56.3	31	15.9	142	72.8
Other circumstance	4	6.3	0	--	27	13.8	0	--

TABLE 2-36

Race and Familial Circumstances by Nature of Case

Circumstances	Serial Abuse Cases				Isolated Incident Cases			
	White		Black		White		Black	
	Present	Absent	Present	Absent	Present	Absent	Present	Absent
Parents evidence intellectual inadequacies	10 25.6	11 28.2	9 37.5	11 45.8	15 12.3	36 29.5	16 25.0	12 18.8
Mother shows evidence of sexual promiscuity and/or drug or alcohol abuse	18 46.2	10 25.6	19 82.6	2 8.7	46 37.7	35 28.7	24 37.5	12 18.8
Parents evidence emotional/psychological problems	31 79.5	3 7.7	15 62.5	6 5.9	74 60.7	20 16.4	37 57.8	6 9.4
Father shows evidence of sexual promiscuity and/or drug or alcohol abuse	12 30.8	9 23.1	3 12.5	3 12.5	39 32.0	23 18.9	10 15.6	7 5.1
Parents evidence physical problems/illness	14 36.8	9 23.7	7 29.2	10 41.7	21 17.2	43 35.2	9 14.3	13 20.6
History or evidence of prior physical abuse to child	32 84.2	5 13.2	14 58.3	9 37.5	27 22.3	43 35.5	14 22.2	26 41.3
Parents experiencing marital problems	21 53.8	10 25.6	8 33.3	12 50.0	62 50.8	21 17.2	16 25.0	18 28.1
Parents experiencing temporary financial problems	18 46.2	10 25.6	14 58.3	1 4.2	54 44.3	31 25.4	35 54.7	11 17.2
Family of low subsistence and general living level	26 66.7	6 15.4	20 83.3	2 8.3	48 39.3	36 29.5	40 62.5	8 12.5
Parent single living with man	2 5.1	36 92.3	5 20.8	16 66.7	5 4.1	109 89.3	3 4.7	44 68.8
Too many children in family for income and/or dwelling	9 23.1	12 30.8	10 41.7	6 25.0	16 13.1	60 49.2	14 22.2	24 38.1

History or Evidence of Prior Physical Abuse to Child.–Evidence of this nature was known in 96.8 percent of the serial abuse cases, with the circumstance being present in 74.6 percent. Among isolated incident cases, the data were known in 58.1 percent of the cases and known to be a circumstance in 21.8 percent. This condition or circumstance was most likely to exist among white serial abuse cases–present in 84.2 percent in comparison to 58.3 percent of the black families. This circumstance was known to be present in less than 25.0 percent black and white families among the isolated incident cases.

Parents Experiencing Marital Problems.–Information regarding marital relations was known in 79.7 percent of the serial abuse cases and in 61.5 percent of the isolated incident cases. From the known information, it appears that marital problems plagued a high percent of parents among both types of cases–the condition was determined to be present in over forty percent of both types. In regard to race, white parents among both types of cases were more likely to have marital problems.

Parents Experiencing Temporary Financial Problems.–A high percent of parents among both types of cases were known to be experiencing temporary financial problems. This type of information was known for 68.8 percent of the serial abuse cases; 50.0 percent of the families were determined to have temporary financial problems. Among isolated incident cases, such problems were present in 46.7 percent of the families and known to be absent in 22.1 percent. Black parents among both types of cases were more likely to have temporary financial problems.

Family of Low Subsistence and General Living Level.–Over seventy percent of the families among the serial abuse cases were known to subsist at a low living level. In only 14.1 percent of these families was this circumstance found not to exist. By comparison, less than fifty percent of the families among the isolated incident cases were known to subsist at a low level of living. In 23.6 percent of the cases, the families were determined to subsist at an adequate level of living. Blacks in general and blacks among serial abuse cases, in particular, were the most likely to be at a low subsistence and general living level.

Neglect Is Chronic.–Neglect as a chronic condition was more likely to characterize families in the serial abuse caseload. Among serial abuse cases, the circumstance was present in 62.5 percent of the cases and absent in only 17.2 percent. This compares to 24.1 percent present and 41.0 percent absent among isolated incident cases.

Child Evidences Intellectual Inadequacies.–By and large, the children were not determined to have problems in intellectual functioning. Such problems were known to be evident in 28.1 percent of the children among serial abuse cases; over forty percent were known not to have such problems. The condition was present in 10.3 percent of the isolated incident cases and absent in 30.9 percent. From the known data, however, it appears that children who were victims of repeated reported abuse were more likely to have problems in intellectual functioning.

Child Evidences Emotional/Psychological Problems.–Evidence indicated that approximately one-third of the children revealed emotional/psychological problems. Among serial abuse cases, 34.4 percent of the children were determined to have such problems; less than one-third were known to be relatively free of problems of this nature. For the children among the isolated incident cases, the condition was determined to be present in 28.2 percent of the cases and absent in 29.2 percent.

Too Many Children in Family for Income and/or Dwelling.–Full information on family composition in relation to income and dwelling was known for 59.4 percent of the serial abuse cases; 29.7 percent of these families were characterized as having too many children for their living circumstances. The circumstance was known to be present for 17.0 percent of the isolated incident cases, and absent for 44.3 percent. Black families were more likely to be characterized by too many children.

Types of Abuse and Family Circumstances

Parents evidence emotional/psychological problems and family at a low subsistence level, were the most common of the familial circumstances. We noted earlier that the most prevalent types of abuse were neglect due to parental inadequacies, physical abuse unrelated to discipline, emotional abuse, and abandonment. Without consideration of race and the nature of the case, we attempted an elementary analysis of types of abuse in relation to family circumstances.

According to Table 2-37. there appears to be a distinct pattern to the clustering of circumstances. The emotional/psychological "state" of the parent(s); the sexual, drug, and/or alcohol consumptive behavior of the female parent/substitute, and family low level of living were the most common circumstances in abandonment cases and in those involving physical abuse determined not to be related to disciplinary measures. On the other hand, in cases of physical abuse where discipline was a motive, history of abuse to the child

TABLE 2-37

Rank Ordered Family Circumstances by Type of Abuse

Type Abuse	Order of Circumstance
Abandonment	2-3-8, 7
Abuse-discipline related	2, 5-6, 12
Abuse-unrelated to discipline	2, 3, 8
Emotional abuse	2, 9, 3
Neglect-parent(s) absent	8, 3, 9
Neglect-parent/child home	3, 9, 2-7-8
Neglect-parental inadequacies	2, 8, 7
Sexual abuse	2-4, 6, 5
Abuse-motive undetermined	1-2-5-10

	Circumstance
1.	Parental intellectual problems
2.	Parental emotional/psychological problems
3.	Mother(s) behavior-sexual, drug, alcohol
4.	Father(s) behavior-sexual, drug, alcohol
5.	History of abuse to child
6.	Marital problems
7.	Temporary financial problems
8.	Low living level
9.	Chronic neglect
10.	Child's intellectual problems
11.	Child's emotional/psychological problems
12.	Child's atypical behaviors

and marital problems both surfaced as the second most common familial circumstance. Behavioral atypicalities of the child was the third most prevalent circumstance in discipline related abuse cases.

An entirely different ordering of circumstances was found in neglect cases. With the exception of neglect resulting from parental inadequacies, the emotional/psychological circumstance was not ranked high. For the cases involving neglect of children due to parental absence, low level of living, sexual-alcohol behavior of the female parent, and chronic neglect were the most prevalent conditions. In neglect cases in which both child and parent were home, mother's behavior and chronic neglect were the most prevalent circumstances; parent's emotional/psychological state, temporary financial problems, and low level of living were all third in order of frequency.

Seriousness of Harm and Family Circumstances

Specific family circumstances stood out in families of reported cases involving serious harm to children. Among serial abuse cases, circumstances descriptive of the adult male appear most likely to be present in cases having serious consequences for children. Harm was of a serious nature in over sixty percent of the cases in which the circumstances of father's sexual, drug and/or alcoholic behavior, father exhibited little love for child, and the mother was living with a man were present.

Among isolated incident cases, parents problems in intellectual functioning and physical problems of the child were the most prevalent circumstance among cases having serious harm for children.

Surprisingly, the family financial situation was not overrepresented in serious abuse cases. See Table 2-38 for a distribution of seriousness and family circumstances.

Comparative Summary of Client Input

1. Characteristics of the Children:

   Age, Sex, Race

   The age range of children who entered both the CES and the PSU systems closely approximated the age distribution discovered in our Regional study and in the National Brandeis study.[2] In each of the earlier studies, as in the present, more than fifty percent of the children were less than six years of age, with approximately one-third being less than three.

   Clearly, the data suggest that, with some degree of consistency, the age distribution of reported maltreated children is highly represented by the young child. Perhaps, a more important finding from the present study is the difference between the serial abuse and the isolated incident cases with respect to the age distribution. The expected which surfaced was the tendency for children among serial abuse cases in each system to be older than those on whom one known report was made. While this was true, the presence of the older child was evident in the isolated incident caseload as well. Among such cases in the CES system, 23.4 percent were of children age ten and above with 12.5 percent being fourteen and above. Of the children in the PSU isolated incident caseload, 26.2 percent were ten and above; 12.3 percent were fourteen and older. These percentages compare to approximately one-third of the children among serial abuse cases in both systems being age ten and above.

   Regarding sex, the distribution for both systems differed somewhat from that found in both the Regional and National studies in which slightly more males than females were reported.

   In the present study, a slightly higher percent of females were among both systems' caseload. Of more importance, however, is the question of which sex was more likely to be victims of repeated maltreatment–among serial abuse cases. In the CES caseload, a slightly higher percent of the males (47.3 percent) than the percent of females (43.6 percent) were among the serial abuse cases. This pattern was not observed in the PSU caseload in which females were more likely to be victims of multiple reports. Of all the females, 29.2 percent were among the serial abuse cases; this compared to 20.8 percent of the males. One explanation of the higher percent of females among the serial abuse cases might lie

[2] Clara L. Johnson, *Child Abuse in the Southeast: Analysis of 1172 Cases* (Fall, 1974). Research Monograph, Regional Institute of Social Welfare Research, University of Georgia, pp. 17-19. David G. Gil, *Nationwide Survey of Legally Reported Physical Abuse of Children*. No. 15, papers in Social Welfare, Brandeis University, Waltham, Mass.: 1968, p. 9. It may be important to note that the age distributions are comparable even though all three studies defined abuse differently.

TABLE 2-38

Seriousness of Harm and Family Circumstances
by Nature of Case

Family Circumstance	Number and Percent Serious					
	Serial Abuse		Isolated Incident		Total Caseload	
Parents intellectual problems	6	35.3	13	43.3	19	40.4
Parents emotional/psychological problems	16	38.1	37	33.9	53	35.1
Mothers-sexual, drug, alcohol	13	38.2	17	25.4	30	29.7
Fathers-sexual, drug, alcohol	8	61.5	14	29.8	22	36.7
Parents physical problems	6	30.0	9	28.1	15	28.8
History of abuse	17	39.5	12	29.3	29	34.9
Marital problems	7	25.9	21	27.3	28	26.9
Temporary financial problems	8	27.6	25	28.4	33	28.2
Low subsistence level	14	33.3	24	27.3	38	29.2
Chronic neglect	16	43.2	16	37.2	32	40.0
Mother-little love for child	3	33.3	10	33.0	13	33.3
Father-little love for child	3	60.0	6	31.6	9	37.5
Child intellectual problems	5	31.3	7	36.8	12	34.3
Child emotional/psychological problems	11	55.0	19	37.3	30	42.3
Child atypical behavior	10	47.6	14	33.3	24	38.1
Child physical problems	5	33.3	10	40.0	15	37.5
Parent single living with man	5	71.4	2	22.2	7	43.8
Parent single living with woman	1	50.0	0	--	1	33.3
Too many children	4	22.2	8	25.8	12	24.5

*Percentages are based on total serious and not serious cases. Cases involving unknown degree of severity are not included.

in the fact that all cases reported to the PSU were not investigated. Perhaps, a sex bias was operating in the dispositional process leading to the decision to or not to investigate.

In terms of the race of children, the composition in the CES total caseload was 73.4 percent white, 22.7 percent black, and 3.9 percent unknown. These findings varied minimally from our regional data–73.1 percent white, 24.5 percent black, 0.9 percent other, and 1.5 percent unknown. On the other hand, Savannah's PSU racial composition–62.1 percent white, 34.0 percent black, and 3.9 percent unknown, closely correspond to Gil's findings of the total national cohort–65.0 percent white, 30.0 percent non-white, and 5.0 percent unknown.

The race of children by the nature of the case, however, presented a different distribution. There was a tendency for a higher percent of all black children than the percent of all white children to be among serial abuse cases. This finding was observed in both systems' data with the differences being more pronounced among CES cases. Well over fifty percent of all black children in the CES caseload were among the serial abuse cases; this compared to 44.0 percent of all white children.

Age and Race

There were distinct differences between the systems with respect to age and race. In the CES caseload, there was a tendency for black children among isolated incident cases to be younger than white children; white children among serial abuse cases tended to be younger than black children. In both types of cases, a higher percent of black children were between the age of ten and fourteen; a higher percent of white children were fourteen and above.

In the PSU caseload, white children among both types of cases tended to be younger. There was no notable difference between the percent white and black who were age ten to less than fourteen. There was, however, a higher percent of black children who were fourteen and above.

By age and race, which children were most likely to be reported for repeated maltreatment? In the CES caseload, the percent of all black children among the serial abuse cases was significantly higher than the percent of all white children at every age level, with the exception of the less than age three. This pattern was not found among PSU cases. In only one age category--three to less than six--were black children found more likely to be in the serial abuse caseload. One must question whether this finding represents the "real" order of things or a bias in the dispositional process leading to decisions regarding the need for investigation.

Sex and Race

In the CES caseload, there were minimal differences between serial abuse and isolated incident cases with respect to the distribution of the sexes for white children. Slightly more than forty percent of all white males and females were among the serial abuse cases. A similar percentage of the black females were among serial abuse cases. On the other hand, approximately two-thirds of the black males were among serial abuse cases. Black males, therefore, were more likely than any other group of children to be involved in repeated reports of maltreatment.

Among the PSU cases, slightly over fifteen percent of all white males and approximately one-fourth of all black females were among serial abuse cases. On the other hand, slightly less than one-third of the white females and of the black males were among serial abuse cases. Thus, white females and black males were more likely to be involved in more than one reported incident.

Age and Sex and Race

Both white and black males in the CES caseload tended to be younger than the females among both types of cases. There was a higher percent of white females than white males among isolated incident cases who were age fourteen and above. There was no difference between the percent of white males and white females among serial abuse cases in the fourteen and above age category. Black females, however, tended to be older than black males in both types of cases.

There were some basic differences noted in the above pattern among PSU cases. In the serial abuse caseload, there was a higher percent of white females than white males who were less than three years old. On the other hand, a higher percent of the white males were less than three among isolated incident cases. For both types of cases, white females were more likely than white males to be fourteen and above. For the black children, females

among both types of cases were more likely than the males to be less than age three. Among serial abuse cases, a higher percent of the black males were fourteen and above; the opposite was found among isolated incident cases.

2. Harm Suffered by the Children:

Types of Abuse

Physical abuse which was determined to be unrelated to disciplinary measures and neglect resulting from parental inadequacies were, by far, the most frequently reported types of abuse for both the children who had been previously reported to the CES system and those involved in single incidents. The third most frequent form was abandonment.

There were variations found in the distribution when we noted the types of abuse by race and the nature of the case. The major differences, however, were between the races. Physical abuse was the most prevalent form for whites and blacks among isolated incident cases. Neglect due to parental inadequacies was the most prevalent form in white cases and abandonment in black cases among the serial abuse cases.

Of the cases reported to the PSU, neglect due to parental inadequacies was by far the most prevalent type of abuse for both white and black children among both types of cases. For white children among serial abuse cases, physical abuse and emotional abuse were the second and third most frequently reported types. For black children, physical abuse and neglect-child/parent home were the second and third. Among isolated incident cases the distribution was the same for white and black children. Physical abuse and abandonment were the second and third most frequently reported types of abuse.

A higher percent of the cases of white children than black children in both systems involved some form of physical abuse. Physical abuse was a more prevalent form among serial abuse cases in the PSU caseload and among isolated incident cases in the CES caseload.

Seriousness of Harm

Approximately one-third of the cases from the CES system were serious in nature. A higher percent of serious cases were in the isolated incident caseload (36.7 percent) than in the serial abuse caseload (29.2 percent).

By comparison, approximately one-fourth of the cases from the PSU system involved serious harm. Serial abuse cases included a higher percent of serious cases (28.1 percent) than did the isolated incident cases (24.1 percent).

Race and Seriousness of Harm

In the CES caseload, a higher percent of both the white and the black children among the isolated incident cases were seriously harmed. For white children in both the serial abuse and the isolated incident cases, over seventy percent of the serious cases involved children under six years of age. Less than ten percent of the serious cases in the serial abuse caseload involved children ten and above; this compared to slightly more than twenty percent in the isolated incident cases.

Only fifty percent of the black children among the serial abuse cases in the CES caseload were less than age six; one-third were age ten and above. By comparison, well over seventy percent of the black children among the isolated incident cases who were seriously harmed were less than six. Slightly more than ten percent were ten and above.

A higher percent of both white and black children among the serial abuse cases were seriously harmed. With the exception for the black children in the PSU serial abuse caseload, PSU serious cases were not overrepresented by the very young child. Among the serial abuse cases, one-third of the white children who were seriously harmed were less than six years old; slightly less than one-third were age ten and over. By comparison, over eighty percent of the black children among the serial abuse cases, who were seriously harmed, were less than six; none were age ten and above.

In the isolated incident caseload, over fifty percent of both the white and black children, who were seriously harmed, were less than six years old; over one-third were age ten and above.

Race, Sex, and Seriousness of Harm

Among both types of cases in the CES caseload, a slightly higher percent of the white females than the percent of white males were seriously harmed. In the serial abuse

caseload, 32.3 percent of the males and 34.4 percent of the females were so harmed. This compares to 37.2 of the males and 40.5 percent of the females in the isolated incident caseload.

The opposite was found for black children in the CES caseload. Among the serial abuse cases, one-third of the males and 28.3 percent of the females were seriously harmed. In the isolated incident caseload, a high of 57.1 percent of the black males and 35.7 percent of the females were so harmed.

Thus, black males were more likely than any other children in CES cases to be both victims of repeated abuse and to be seriously harmed.

In the PSU caseload, a higher percent of both white and black males than the percent of females were seriously harmed among the serial abuse cases. For the white children, among the serial abuse cases, 46.2 percent of the cases involving males and 25.0 percent of those involving females were serious. For the black children, 36.4 percent of the males and 20.0 percent of the females were seriously harmed.

On the other hand, a higher percent of both white and black females than the percent of males were seriously harmed among the PSU isolated incident cases. For the white children, 28.3 percent of the females and 23.3 percent of the males were seriously harmed. For the black children, 35.5 percent of the females and only 14.3 percent of the males were seriously harmed.

Thus, while black females were less likely than were white females and black males to be involved in multiple reports, they were the group most likely to be seriously harmed when considering the total caseload. Black males were the least likely to be seriously harmed.

3. Involvement in Prior Incidents:

Prior Reported Incidents

We noted earlier that a slightly higher percent of males were among CES serial abuse caseload than the percent of females. Beyond the fact of being more likely involved in more than a single incident, males were also reported more often. Only 3.9 percent of the females, as compared to 20.8 percent of the males were involved in two or more prior reported incidents.

In addition to being a more likely victim of prior reported incidents, black children in the CES serial abuse caseload were also found to be more likely involved in two or more prior reports.

In the PSU caseload, females were more likely to be in the serial abuse caseload while males among the serial abuse cases were reported more often. Approximately ten percent of the females and twenty percent of the males had been investigated following two or more prior reports.

While black children in the PSU caseload were more likely to be among the serial abuse cases, white children were more likely to be involved in two or more prior investigated incidents.

Prior Reported Incidents and Age

A general pattern surfaced in both systems with respect to the number of prior reports and age--the two youngest age groupings, i.e., less than three and three to less than six, and the oldest category of children age fourteen and over--were the least likely to be involved in more than one prior reported incident. In the CES serial abuse caseload, well over eighty percent of the fourteen and above, slightly more than seventy percent of the less than age three, and nearly seventy percent of the three to less than six were involved in only one prior report. In the PSU caseload, slighty over eighty percent of the two youngest groups of children and three-fourths of the oldest were involved in one prior report.

Contrary to a preconceived notion that the oldest children in the serial abuse caseloads would also be the most often reported, we found that the middle age groupings of children in both the CES and the PSU caseloads were the most often reported.

In the CES serial abuse caseload, only 39.1 percent of the six to less than ten year old children and 52.9 percent of the ten to less than fourteen were involved in only one prior incident. Similarly for the PSU serial abuse cases, 43.7 percent of the former age group and 46.2 percent of the latter were involved in one prior incident.

Prior Placement History

A higher percent of the PSU serial abuse cases involved children who had, at some previous time, been in

placement–28.1 percent in comparison to only 15.1 percent of the CES serial abuse cases.

A higher percent of males were among the children in the CES cases who had been in placement. Of the males among the serial abuse cases, those with a placement history represented close to twenty percent. This compares to 11.8 percent of the females in the serial abuse caseload.

In the PSU caseload, slightly more females had been in placement. However, males were more likely to have a prior placement. Of the 26 males in the serial abuse caseload, 8 or 30.8 percent had been placed. This compares to 10 or 26.3 percent of the 38 females.

In both the CES and the PSU prior placement caseload, approximately two-thirds of the children were white. In the CES caseload, however, the percent of all black children with a placement history (5 or 17.9 percent) was higher than the percent of all white children (11 or 14.9 percent). The opposite was found in the PSU caseload where 30.0 percent of all whites and 25.0 percent of all blacks had a known prior placement(s).

Regarding age and placement history, in both systems the middle age categories–six to less than ten and ten to less than fourteen–as with the number of prior reports, were also more represented among those with a prior placement. By noting the number of children in each age group with a placement history in relation to the total number of children among the serial abuse cases in each age group, we determined that the two middle age groups were the most likely to enter placement in both systems, with the exception of the high percent of the fourteen and older children in the PSU.

4. Perpetrators of Harm:

Identity of Perpetrator

In both systems, the child's mother or mother substitute was the perpetrator in an overwhelming majority of the cases. Among the CES cases, white mothers/substitutes were indicated in 64.9 percent of the cases and black mothers in 73.1 percent. This compares to 68.9 percent white mothers/substitutes and 84.1 percent of the black in the PSU caseload.

Seriousness of Harm and Perpetrator

Among the CES cases, fathers/father substitutes of both races were responsible for the highest percentage of cases involving serious harm. Black mothers were the least likely to be responsible for serious harm.

Among the PSU cases, white fathers/substitutes were involved in the highest percent of cases in which serious harm was perpetrated. Black mothers/substitutes were responsible in a higher percent of such cases than were black fathers/substitutes. White mothers were the least likely to be involved in serious cases.

5. Family Circumstances Present:

Prevalence of Circumstances

In both systems' total caseload, parent(s) evidences emotional/psychological problems and low level of living were the most prevalent circumstances. In the CES caseload, history of abuse was the third ranked circumstance. The third in the PSU caseload was temporary financial problems. Mother's sexual, drug and/or alcohol consumptive behavior was the fourth most prevalent circumstance in both systems' cases.

The major difference in the ordering of circumstances by observed frequency existed between the types of cases–serial abuse and isolated incident–rather than between systems. Among serial abuse cases in both systems, history of abuse was the most prevalent circumcircumstance; low level of living was second among the CES cases and third in the PSU caseload; parent(s) emotional/psychological problems in the PSU caseload was second and in the CES was third; the fourth ranked circumstance in both systems' caseload was chronic neglect.

Among both systems' isolated incident cases, parent(s) emotional/psychological problems and low living level were the first and second most frequently ranked circumstances. Mother's sexual, drug and/or alcohol consumptive behavior and history of abuse were the third and fourth most prevalent circumstances among the CES cases. Among the PSU cases, temporary financial problems and marital problems were so ranked

Prevalence of Circumstances and Race

We noted in the preceding section that there were minimal differences between the systems in terms of the ordering of circumstances by observed frequency; the major difference existed between the types of cases. In relation to prevalence of circumstances by the race of the family, we found that differences existed between the races as well as between the types of cases, i.e., in a general sense, white families in one system's caseload were more like white families in the other system's than like black families in the same system and vice versa. Further, in terms of the ranked ordering of circumstances, white families in one system's serial abuse caseload were more like white families in the other system's serial abuse caseload than they were like white families in the same system's isolated incident caseload. This held true for black families.

In both systems' total caseload, parent(s) emotional/psychological problems was the most frequently observed circumstance among white families; the most frequently observed among black families was low level of living. Mother's sexual, drug and/or alcohol consumptive behavior became one of the most prevalent circumstance among black families in both systems' caseload, white marital problems surface as a prevalent circumstance among white families.

Family Circumstances and Types of Abuse

Without consideration of race and the nature of the case, we performed elementary analyses of types of abuse by family circumstances.

Given some minor deviations, a distinct pattern to the clustering of circumstance was observed in both systems' caseload. In general, we observed that:

1) in cases of abandonment and those in which physical abuse was not related to disciplinary measures, the emotional/psychological problems of the parent(s), the mother's sexual, drug and/or alcohol consumptive behavior, and the low level of living were the most common circumstances;

2) in cases of physical abuse where discipline was being exercised, history of abuse and child's atypical behaviors emerged as frequently observed circumstances;

3) in both systems, parent(s) emotional/psychological problems was not a frequently observed circumstance in cases involving neglect due to the absence of parents–in the same order for both systems' cases, low level of living, mother's behavior, and chronic neglect were paramount;

4) in general, with the exception of neglect resulting from parental inadequacies, the emotional/psychological circumstances was not ranked high.

Family Circumstances and Seriousness of Harm

Specific family circumstances stood out in families of reported cases involving serious harm to children. While there were observed differences between the systems' caseloads, as well as differences between the types of cases, we found that, in general, circumstances relative to the child's emotional, behavioral, and/or physical problems appeared most likely to be present in cases having serious consequences for children. Harm was also of a serious nature when parents evidenced intellectual problems and when the mother lived with a man.

Among the circumstances which were not present in a high percent of serious cases were the family's financial conditions, the mother's sexual and/or drug/alcohol consumptive behavior, parents' physical problems, marital problems, and too many children.

Chapter 3

SYSTEMS RESOURCE INPUT: STAFF AND SERVICES

From recent research on abused and neglected children, we have come to realize that child abuse and neglect are symptomatic of family problems. While not all, many of these children come from families in which acute and complex problems exist. In order that children and families can be successfully treated toward the end of preventing further abuse and neglect and preserving family life where possible, the child protective service program must have adequate staff to meet the demands and the needs of all cases reported.

The adequacy of staff must be viewed in terms of caseload levels and workers' preparation and training. The generally accepted "standard" of caseload level is no more than twenty-five families per protective service worker.[1] Too often, however, the worker-family ratio does not approximate the standard.

Beyond these considerations, staff must be well prepared and trained to work with abused and neglected children and their families. What preparation is required, however, has not been clearly identified. In relation to the degree of preparation, some make a case for while others argue against the utilization of workers with bachelor degrees at the direct service level.[2] Most such arguments are based on a presumption of preparation in the field of social work or closely related areas. Experience indicates, however, that arguments regarding extent and content of workers' preparation are of little consequence in most states. What matters is their realistic situation; the overwhelming majority of child protective service caseworkers hold only the bachelor's degree.[3] The area of undergraduate preparation is often in an unrelated field.

Preparation in the field of social work includes socialization to a set of values, the acquisition of a body of theoretical and applied knowledge, and practical experience in performing the functions of a professional social worker.

In view of the fact that many workers in child protective services come from diverse and unrelated backgrounds, and the body of knowledge is ever growing, on-going training becomes an essential part of the total program.

Beyond adequate staff, an array of services must be readily available. In the main, two basic groups of services are normally available:

1. services to children requiring placement outside the home, and

2. services to children and families in their own home.

For both groups of services, the child protective service worker must have access to other social work resources in the community.

Adequate staff and the availability of services, in large measure, are dependent upon adequate appropriated funds.[4] However, the appropriated service dollar seems to

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[1] The Child Welfare League of America and the American Humane Association propose the 1:25 worker-family ratio, with a 1:20 ratio considered more optimal.

[2] For a pro-argument see: John A. Brown and Robert Daniels, "Some Observations on Abusive Parents," *Child Welfare*, XLVII (February, 1968), pp. 89-94. See: Andrew Billingsley, *The Social Worker in a Child Protective Agency* (New York: National Association of Social Workers, 1964), mimeographed for an arguement against. Also see: Robert R. Carkhuff, "Differential Functioning of Lay and Professional Helpers," *Journal of Counseling Psychology*, 15 (March, 1968); and Wallace J. Gingerich, Ronald A. Feldman, and John S. Wodarski, "Accuracy in Assessment: Does Training Help?" *Social Work*, Vol. 21, No. 1 (January, 1976), pp. 40-48.

[3] For a discussion of child protective service staff in the states in Region IV see: Clara L. Johnson, *Child Abuse: State Legislation and Programs in the Southeast*. Research Monograph (August, 1973), Regional Institute of Social Welfare Research, University of Georgia, Chapter 4.

[4] As indicated earlier, one of the major limitations of this study is the lack of data regarding the availability of funds. With this limitation in mind, a general statement must suffice. The CES was a federally funded demonstration project which was monitored by the U.S. Department of HEW, OCD. The administering organization was the public state agency. The PSU was a unit of the Department of Family and Children's Services supported by state, county, and state administered federal funds.

be diminishing in spite of the child protective services need for more specialized and adequately trained staff, smaller worker caseloads, a diversity of services to children and their families, and alternatives for children requiring out-of-home placement.

This chapter deals in detail with the direct service casework staff of both systems. As specific services will be noted in Chapter 4, which deals with agency activities, related discussion in this chapter will outline the general categories of available services.

No attempt was made to assess worker's perception of the adequacy/inadequacy of quality and content of services. In an earlier Regional study, we found that state personnel evaluated services designed to help remedy abusive family situations; namely, casework, foster care, institutional care, and day care as most inadequate in quality and content. The more specialized service, e.g., medical, legal, psychiatric, etc., were considered adequate in quality and content but more inaccessible than the former types of services.[5]

Staff and Services in the CES System Nashville, Davidson County, Tennessee

Service Providers in the CES System

Staff Composition.–The staff of the Comprehensive Emergency Services Project (CES) was specialized in that workers were specifically identified as protective service workers. Toward the end of the project's funding as a federally funded demonstration project, CES as comprised of the following staff:

- Director of the Project
- Five Emergency Service Intake Workers (caseworkers)
- One Supervisor of the Emergency Service Unit (at times this supervisory function was the responsibility of the Project Director)
- Ten Emergency Homemakers (at an earlier stage of the project, there were four)
- One Supervisor of Emergency Homemakers
- Two Welfare Workers II (responsible for recruitment and supervision of emergency homes in the foster homes component of the program–previously there were three such workers).

Much of the direct service was performed by the Emergency Services Intake Workers who were responsible for intake, initial case handling in most cases, and outreach and follow-up in a large proportion of cases. Each worker carried an active caseload of approximately forty families and was responsible with the supervisor for coordinating and obtaining services of the appropriate project service components, other community resources, and/or intra-agency case transferral.[6]

The CES caseworkers represented a relatively young staff. Four workers were less than thirty years of age; one was above fifty.

In regard to sex, there were three male and two female caseworkers. Three of the workers were married; only one was a parent.

At the time of the study, all of the caseworkers in the CES project were white. On the other hand, the homemakers were black.

Education and Training of CES Caseworkers.–While the "professional" level service staff was designated as specialized, the evidence indicates that in terms of the extent and content of education, the level of experience and training, specialization in terms of protective services, per se, could be questioned.

All of the five Emergency Service Intake Workers held the bachelor's degree, with one worker taking courses leading to the masters. Table 3-1 following shows the educational, work, and training backgrounds of the CES casework staff. In regard to education, none of these direct service workers held the degree in social work/social welfare.

If we assume that a "professional" social work background is not essential to the delivery of protective services, we would have to further assume that, if a special set of values, skills, and knowledge are required, the acquisition of these would have to be obtained through other channels. To determine the extent to which the acquisition of protective service working values, skills, and knowledge had been

[5] Clara L. Johnson, *Child Abuse: State Legislation and Programs in the Southeast*, pp. 51-52.

[6] For a discussion of CES procedural operations, see Chapter 4 in Clara L. Johnson, *Two Community Protective Service Systems.*

TABLE 3-1

Education and Training of CES Casework Staff

College Major**	Work Experience		Professional Growth Experiences			Related Work Experiences*
	Social Welfare	Protective Services	Workshops Institutes	Professional Meetings/ Conferences	In-House Staff Training	
Unrelated	5 < 7 years	1 < 3 years	2	1	on-going irregular	yes
Unrelated	1 < 3 years	1 < 3 years	0	1	sporadic	yes
Unrelated	3 < 5 years	3 < 5 years	3	3	sporadic	yes
Related	6 mos. < 1 year	< 6 mos.	1	0	on-going irregular	yes
Unrelated	1 < 3 years	1 < 3 years	1	2	sporadic	no

*Examples presented to workers were camp counselor, scout leader, volunteer family worker.
**The relatedness of college majors was determined from ratings of a panel of judges comprised of persons in social work and in the area of the specific major.

possible, we asked each caseworker to indicate the years of work experience in the broad area of social welfare and in the specialized area of protective services. Three of the workers had been in the area of social welfare for less than three years; four workers had been in protective services for less than three years.

In terms of recent training and educational experiences, we asked the workers to indicate the number of workshops/institutes and professional meetings attended, and the extent of in-house staff training. There appeared to be limited involvement in these kinds of activities. Four workers had attended at least one workshop/institute, with two having attended only one. Three of these workers had also attended at least one professional meeting/conference.

In-house staff training was characterized as being sporadic by three of the caseworkers and as on-going but irregular by two. None of the caseworkers viewed staff training as an on-going and regular process.

Another possible channel, through which one might conceivably gain insight into and some of the values and skills for the delivery of protective services, would be through related work experiences. Each worker was asked to indicate the number and type of work related experiences in which they had been and/or were presently involved. While not being specific regarding number and type, four workers indicated they had had such related experiences.

In view of the caseworkers' college degrees being primarily in areas totally unrelated to social work or indirectly related at best, their limited involvement in professional growth experiences, and the irregularity in staff training, one could easily conclude that much of the expertise the CES staff possessed was derived through personal development, e.g., aggressive reading in the area, and the passage of "in-unit" knowledge. One has to question, however, in-unit knowledge when one considers that three of the caseworkers, two having unrelated educational backgrounds, were undoubtedly introduced to the fields of social welfare and protective services during the life of the project.

Services in the CES System

The CES system represents a unique way of coordinating services designed to maintain children in their own home or to ensure quick return should placement be necessary. The service components were intricately tied to the emergency unit which allowed for immediate response to situations and the offering of ameliorative services without the disadvantages of bureaucratic red tape.

In addition to the existing services, the CES program in Nashville was comprised of four basic service components; namely, *twenty-four hour emergency intake, emergency caretaker services, emergency homemaker services,* and *emergency foster home services.*[7] For ease in presentation and for the purpose of demonstrating how these coordinated services were a part of a more comprehensive service picture, these service components will be discussed as elements of the basic groups of services.

Intake-Referral Services.–While intake is a function/activity of a system's operation, it is at the same time a service. Entry into the system, initial actions to be taken, counseling, and referral to other appropriate community resources are the major services subsumed under intake.

The intake-referral service of a protective service unit should be accessible for intake on a twenty-four hour basis and should involve cooperative and coordinated linkages with the parent agency and with other service agencies in the community. The emergency intake component of the CES project, which was an expansion of the existing eight hour-five day week protective service intake process, was accessible on a twenty-four hour basis.

During work hours, compiaints were taken by the emergency service intake worker. The intake worker had the responsibility of determining the action to be taken. Some cases were referred to other community resources. In non-serious cases which were appropriate to the services of CES, social services were offered. The emergency service intake worker conducted the intake and investigative processes in such cases, but reportedly were not generally responsible for the on-going handling of such cases. Each case defined as serious or an emergency was assigned by the intake worker and the supervisor for immediate investigation and assessment.

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[7]For a full description of these components and operating cost information, see National Center for Comprehensive Emergency Services to Children, *Comprehensive Emergency Services: Community Guide* (Nashville, Tennessee: Nashville Urban Observatory, 1974), pp. 47-52. Also see Chapters 12 and 16 for a description of components added to the initial program, Emergency Shelter for Families and Adolescents, respectively. For an evaluation of CES operations, see Clara L. Johnson, *Two Community Protective Service Systems,* pp. 20-24.

After work hours, the DPW emergency intake answering service received complaints. Upon preliminary screening, some callers were referred to other community resources; emergency or crisis situations were referred to the emergency intake worker "on call." The intake worker determined, from available information, the nature of the situation. Non-serious/non-emergency situations were either referred to appropriate agencies or to outreach and follow-up. Situations "defined" as emergency in nature were assigned for immediate field investigation.

In-Home Services.–In child abuse and neglect cases in the CES system, the decision to allow children to remain in the home with services was made in the following major types of situations:

1. in-home awaiting court hearing;

2. in-home pending resolution of an immediate crisis, e.g., absence of parent; and

3. in-home with services as the agency's long-term disposition.

Unique to the CES system was the availability of services designed to maintain the child in the home under the first and second general types of situations. A discussion of these service components follows.

Emergency homemaker services were available on a twenty-four hour basis. While the emergency homemaker services were designed for the purpose of maintaining children in their own home until the resolution of a crisis, homemakers were utilized in any of the situations in which the decision was made to allow children to remain in the home with services.

The services provided by homemakers were numerous and varied according to the demands of the specific situation. Reportedly, one of the most beneficial services performed by the homemakers was that of observing the child and family. Such observations were considered invaluable to the intake worker and the supervisor in their assessment of family problems. In abuse cases, in particular, homemakers functioned pretty much as a lay therapist.

In some situations of the second type–in-home pending resolution of an immediate crisis–homemakers stayed in the home on a twenty-four hour basis. In such instances, homemakers rendered services to the family until an absent parent returned, other arrangements were made, and/or parent(s) was able to carry out routine parental responsibilities.

Emergency caretaker services were also available on a twenty-four hour basis. Caretakers provided temporary care, usually for only a few hours until a homemaker was assigned primarily in situations of the second type. The tasks they performed were essentially the same as the homemaker usually being assigned at nights and on weekends. According to CES personnel, this service was never fully developed; homemakers eventually took over caretakers' roles as functions began to overlap.

Casework services were provided by the emergency intake workers under the supervision of the supervisor of the intake workers. Beyond intake and investigative functions, the caseworker was responsible for assessing the child's and family's needs, developing a goal-oriented treatment plan, and obtaining and coordinating services and activities.

Paramount to casework services is the availability of such professional services as medical and psychological and/or psychiatric.

There was a major limitation to the utilization of psychological services. While the reporting law stipulated that all abused children were to receive psychiatric evaluations, there was no mechanism in the law to deal with payment for such services to persons who were not active AFDC cases. Beyond these limitations, mental health facilities were generally reluctant to accept CES referees especially in relation to physical or sexual abuse. It was felt, according to CES personnel, that they were being requested to evaluate a situation in which what was revealed could be used to determine whether or not a child would be removed from the home. Beyond reluctance to accept referees, the time involved in getting eventual requested evaluations was often lengthy.

In addition to the service components of the CES project, such basic services as day care were available for eligible families through the parent agency.

Out-of-Home Services.–Out-of-home services offered directly by the CES program were *emergency foster home services*. These services were designed to minimize the emotional shock of the removal of children from their own homes by providing them with a home environment as an alternative to the routine housing of all children temporarily in an institutional placement prior to court hearings.

Emergency foster homes differ from regular foster homes in that they receive children at any hour and usually without preparation such as preplacement visits. Children are usually placed for shorter periods of time.

Regular out-of-home services such as regular foster care, group care, institutional care, etc., were provided through the services of the parent agency.

Staff and Services in the PSU Savannah, Chatham County, Georgia

Service Providers in the PSU System

Staff Composition.--The Protective Service Unit (PSU) was one unit of the parent social service agency. The PSU, which was operationally and structurally tied to the parent system, was designed as a separate unit to provide crisis intervention and short-term services.

At the time of the study, the PSU was comprised of six workers, one being the supervisor of the Unit. Beyond intake and handling the identified emergency or resolving the immediate crisis, PSU caseworkers were not responsible for case handling. Beyond intake and investigation responsibilities, PSU caseworkers consulted with and advised workers assigned to cases requiring court action.[8]

In regard to age, the PSU caseworkers were all less than thirty-five, three being less than age thirty.

Three of the workers were male, two female. All of the workers were married and living with their spouse. Two workers had no children. Four of the caseworkers were white, one black.

Education and Training of PSU Caseworkers.--The staff of the PSU was considered specialized in that such staff were designated for handling abuse and neglect cases. In terms of assumed required value orientation, skills, and knowledge, how specialized were the protective service caseworkers?

We were successful in obtaining interviews from four of the Unit's six workers, including the Supervisor, and one general caseworker who also carried protective service cases. All of the interviewees held the bachelors degree. According to Table 3-2, only one worker in the Unit majored in an area considered to be totally unrelated to the field of social work.

From the self-report of the workers, there appeared to be a goodly amount of staff involvement in activities presumed to provide professional growth. Four workers had attended at least two workshops/institutes and at least two professional meetings or conferences.

In-house staff training was described as sporadic by three workers and as on-going but irregular by two. Staff training was not viewed as an on-going process.

As to prior participation and/or present involvement in work related activities, only one of the workers, the unit's supervisor, indicated such involvement. Thus, work related experiences as a channel through which incidental learnings of possible value to protective service work were not common among the PSU caseworkers.

In terms of work experience in the general area of social welfare, three of the caseworkers had less than three years, with one of these being in protective services for less than six months and one for less than one year. While two of the workers, one being the supervisor of the Unit, had at least three years of work experience in social welfare, they had less than three years of experience in protective service work.

Services in the PSU System

One of the major limitations of the protective service unit of DHR was the lack of coordination and available emergency services which could be brought to bear without the disadvantages of bureaucratic red tape.

Intake-Referral Services.--The Protective Service Unit (PSU) of DHR provided for intake during the work day (8:00 a.m. through 5:00 p.m.) five days a week. Complaints were handled by law enforcers after DHR's work day and on weekends.

It was at the point of intake that major decisions regarding initial case handling were made. The PSU intake worker had the major responsibility for determining the channel cases took, i.e., outside referral, other unit within the agency, PSU investigation and intervention, or no action.

There was a decided lack of coordination between PSU and the law enforcement and the Juvenile Court system in the intake-referral processes.

[8] For a discussion of PSU procedural operations, see Chapter 5 in Clara L. Johnson, *Two Community Protective Service Systems*.

TABLE 3-2

Education and Training of PSU Casework Staff

College Major	Work Experience		Professional Growth Experiences			Related Work Experience
	Social Welfare	Protective Services	Workshops/ Institutes	Professional Meetings/ Conferences	In-House Staff Training	
Related	1 < 3 years	6 mos. < 1 year	1	2	sporadic	no
Mildly Related	3 < 5 years	1 < 3 years	2	2	sporadic	no
Related	7 < 10 years	1 < 3 years	*	6	on-going irregular	yes
Unrelated	1 < 3 years	1 < 3 years	4	5	on-going irregular	no
Mildly Related	1 < 3 years	< 6 mos.	6	2	sporadic	no

*Numerous was indicated rather than a specific number by this respondent.

In-Home Services.–One of the major differences between CES and PSU existed in the availability of services which could be brought to bear in crisis situations; namely, in-home awaiting court hearing and in-home pending resolution of an immediate crisis.

Protective Service Unit workers were limited in the alternatives they could call upon without bureaucratic red tape. For example, in situations which could be considered dangerous to children but which could be resolved without removal if an outside force could be placed in the home to aid in the stabilizing process, PSU workers only had the option of removing or allowing the children to remain in the situation. There were DHR homemakers, however, but they were not available to PSU workers on a "moment's notice." Requests had to be made; eligibility had to be shown; and so on, more red tape. In fact, homemakers were not available to protective service workers at all unless clients were AFDC recipients.

PSU workers were responsible for intake and handling the identified emergency or resolving the immediate crisis; they were not responsible for case handling. Thus, beyond intake, the investigative process, initial assessment, and stabilizing processes there were virtually no in-home services tied to or rendered by the PSU.

Casework services, including professional referrals, were available as an in-home service in situations in which the agency's "long-term" disposition was to allow the child to remain in the home with services. Such services were provided primarily by caseworkers in some other unit of DHR.

Out-of-Home Services.–Beyond the regular out-of-home services provided through the service channels of the parent agency, there were no out-of-home services available to caseworkers in the PSU system.

Comparative Summary of Resource Input

1. Adequacy of Staff:

Protective Service Staff Caseload

Each emergency service intake worker in the CES system carried an active caseload of approximately forty families and was responsible, with the supervisor, for obtaining and coordinating services of the appropriate project service components, other community resources, and/or intra-agency case transferral. These protective service workers were not only responsible for resolving crises, they were responsible for long-term case handling which involved cases falling at different points in the protection process; namely, children not placed, those placed, and those in the court process. Thus, their function was intake, field assessment, and case handling.

By contrast, the protective service workers in the Savannah's Protective Service Unit (PSU) were not generally responsible for case handling beyond intake and handling the identified emergency or resolving the immediate crisis. In addition to these responsibilities, PSU caseworkers consulted with and advised workers assigned to cases requiring court action.*

Staff Preparation and Training

The adequacy of staff in terms of preparation and training was noted from the extent and content of education and the level of experience and training. In the CES system, all of the five caseworkers held the bachelor's degree, with one worker taking courses leading to the masters. None of the workers, however, held the degree in social work/social welfare. In fact, four of the workers' college major was in a totally unrelated area. By comparison, while none of the PSU workers held the bachelor's degree in social work/social welfare, only one worker's major was in an unrelated area.

In both systems, the workers tended to have one to less than three years of work experience in protective services and in the broader area of social welfare.

In terms of recent training and educational experiences, i.e., workshops/institutes, professional meetings, there was limited involvement of CES workers in these kinds of activities. On the other hand, there was a goodly amount of PSU staff involvement in such activities.

Both systems' staff generally characterized their in-house training as either sporadic or as on-going but

*In terms of functions and responsibilities, therefore, we have dealt with different kinds of staff–in the CES system, the protective service workers were the intake, crisis intervener, and follow-up or long-term caseworker. On the other hand, the two former functions were performed by the PSU caseworkers, while long-term case handling was the responsibility of generalists in another unit of the parent agency.

irregular. None of the workers viewed staff training as an on-going and regular process.

2. Available Services:

Intake-Referral Services

The intake-referral service of the CES system, which was coordinated with that of the juvenile court, was accessible on a twenty-four hour basis. The PSU in Savannah provided for intake during the work day (8:00 a.m. through 5:00 p.m.) five days a week. Complaints were handled by law enforcers after the agency's work day and on weekends. There was a decided lack of coordination between PSU, the law enforcement, and the juvenile court systems in the intake-referral processes.

In-Home Services

Unique to the CES system was the availability of services designed to maintain the child in his own home while awaiting the court hearing and during the resolution of an immediate crisis, e.g., absence of a parent(s). These major service components–emergency homemaker services and emergency caretaker services–were available on a twenty-four hour basis. These kinds of services were not available in the PSU.

Both systems provided casework services and an array of rehabilitative services for both children and their families. In the CES system, casework services were provided by the unit's protective service workers. In the PSU system, these services were provided primarily by general caseworkers in some other unit of the parent agency.

Out-of-Home Services

Both systems offered regular out-of-home services such as regular foster care, group care, institutional care, etc., through service channels of the parent agency. Beyond these traditional kinds of services, the CES program offered emergency foster home services. This service, available on a twenty-four hour basis, was a structural component of the CES system and therefore readily available for the caseworkers' use.

Chapter 4

SYSTEMS OUTPUT: DISPOSITIONS MADE AND SERVICES RENDERED

System output refers to the activities of and the services rendered by the system in processing the clients. The provision of services is undoubtedly influenced by their availability and by the decisions made regarding the actions in reported cases. This chapter is devoted to the decisions made by the protective service systems and the services rendered in actual cases.

Dispositions and Services in the CES System

Case Dispositions

The two most frequent case dispositions were: (1) to allow the child to remain in the home with services and (2) to petition for the temporary removal of the child. Emergency removal of the child was the third most frequent disposition.

There were some slight differences in agency disposition by the nature of the case. The disposition to allow children to remain in the home with services was more likely made in serial abuse cases--in 44.3 percent in comparison to 36.7 percent of the isolated incident cases. On the other hand, petition for temporary removal of the child and emergency removal were slightly more frequent dispositions for children among isolated incident cases.

The complete distribution of agency dispositions by the nature of the case is presented in Table 4-1.

Age and Selected Dispositions

Differences in selected dispositions by the age of children are noted in Table 4-2.

Among serial abuse cases, children in the youngest (less than three years of age) and the oldest (fourteen to less than eighteen) age groupings were least likely allowed to remain in the home with services--less than thirty-five percent of the children in these age groupings as compared to forty-five percent or more of the children in the other age categories. Similarly, the youngest children (29.0 percent) and the oldest children (18.8 percent) were the most likely removed on an emergency basis and to have petitions for temporary removal filed on their behalf.

Among isolated incident cases, the decision to allow children to remain in the home with services was least likely made in cases involving children age ten to less than fourteen (13.3 percent). On the other hand, the disposition to petition for temporary removal was most likely made in their behalf (66.7 percent). Also, 20.0 percent of these children were removed from their homes on an emergency basis. There was little difference between the percent of the three youngest groups of children who were removed on an emergency basis--23.1, 28.6, and 25.0 percent, respectively and who had petitions for temporary removal filed on them--33.8, 28.6, and 30.0 percent. In only 5.6 percent of the cases of children age fourteen to less than eighteen was the disposition of emergency removal made; however, the disposition to petition for temporary removal was made in 50.0 percent of these cases.

Sex and Selected Dispositions

The disposition to allow the child to remain in the home with services was more likely made in cases involving females. While a higher percent of all females were removed on an emergency basis, the decision to petition for temporary removal was made in a higher percent of the cases involving males.

Regarding agency decision by the nature of the case, there were some differences from the distribution noted in the total caseload. Among serial abuse cases, 45.3 percent of the females and 37.3 percent of the males were allowed to remain in the home with services. Over twenty percent of the females and slightly over ten percent of the males were removed on an emergency basis. The disposition to petition for temporary removal was made in 26.4 percent of the cases in which females were involved and in 44.0 percent of those involving males.

The pattern for isolated incident cases remained the same; however, the differences were less pronounced. Over thirty percent of the males (31.7 percent) and females (36.0 percent) remained in the home with services. Approximately twenty percent of males and females were removed on an emergency basis. The decision to petition for temporary removal was made for 41.7 percent of the males and for 36.0 percent of the females. These data are reported in Table 4-3.

TABLE 4-1

Agency Disposition by the Nature of the Case

Case Disposition	Nature of Case: Serial Abuse No.	Serial Abuse Percent of Cases* (N=106)	Serial Abuse Percent of Disposition	Isolated Incident No.	Isolated Incident Percent of Cases* (N=128)	Isolated Incident Percent of Disposition	Total
Child remain in home without services	0	--	--	7	5.5	4.1	7 3.0
Child remain in home with services	47	44.3	34.1	47	36.7	27.8	94 40.2
Emergency removal of child	20	18.9	14.5	30	23.4	17.7	50 21.4
Emergency removal of other children	10	9.4	7.2	9	7.0	5.3	19 8.1
Petition for temporary removal of child	40	37.7	29.0	53	41.4	31.4	93 39.7
Petition for temporary removal of other children	10	9.4	7.2	11	8.6	6.5	21 9.0
Petition for permanent removal of child	4	3.8	2.9	2	1.6	1.2	6 2.6
Petition for permanent removal of other children	0	--	--	1	0.8	0.6	1 0.4
Informal placement with other relatives	7	6.6	5.1	9	7.0	5.3	16 6.8

*Percentages add up to an excess of 100 since more than one disposition was made in some cases.

TABLE 4-2

Age and Selected Agency Dispositions by Nature of Case

Age	Agency Dispositions															
	Total Caseload				Serial Abuse				Isolated Incident							
	Child Remain Home With Services	Emergency Removal	Petition Temporary Removal	Informal Placement	Child Remain Home With Services	Emergency Removal	Petition Temporary Removal	Informal Placement	Child Remain Home With Services	Emergency Removal	Petition Temporary Removal	Informal Placement				
< 3	33 34.4 (35.1)	24 25.0 (48.0)	34 35.4 (36.6)	5 5.2 (31.3)	10 32.3 (21.3)	9 29.0 (45.0)	12 38.7 (30.0)	0 --	23 35.4 (48.9)	15 23.1 (50.0)	22 33.8 (41.5)	5 7.7 (55.5)				
3< 6	19 40.4 (20.2)	9 19.1 (18.0)	12 25.5 (12.9)	7 14.9 (43.8)	13 50.0 (27.7)	3 11.5 (15.0)	6 23.1 (15.0)	4 15.4 (57.1)	6 28.6 (12.8)	6 28.6 (20.0)	6 28.6 (11.3)	3 14.2 (33.3)				
6<10	20 45.5 (21.3)	8 18.2 (16.0)	15 34.0 (16.1)	1 2.3 (6.3)	11 45.8 (23.4)	3 12.5 (15.0)	9 37.5 (22.5)	1 4.2 (14.3)	9 45.0 (19.1)	5 25.0 (16.6)	6 30.0 (27.3)	0 --				
10<14	10 31.3 (10.6)	5 15.6 (10.0)	16 50.0 (17.2)	1 3.1 (6.3)	8 47.0 (17.0)	2 11.8 (10.0)	6 35.3 (15.0)	1 5.9 (14.3)	2 13.3 (4.3)	3 20.0 (10.0)	10 66.7 (18.9)	0 --				
14<18	12 35.3 (12.8)	4 11.8 (8.0)	16 47.0 (17.2)	2 5.9 (12.5)	5 31.2 (10.6)	3 18.8 (15.0)	7 43.8 (17.5)	1 6.2 (14.3)	7 38.9 (14.9)	1 5.6 (3.3)	9 50.0 (17.0)	1 5.6 (11.1)				
	94 37.2	50 19.8	93 36.8	16 6.3	47 41.2	20 17.5	40 35.1	7 6.1	47 33.8	30 21.6	53 38.1	9 6.5				

TABLE 4-3

Sex and Selected Agency Dispositions by Nature of Case

Sex	Agency Dispositions															
	Total Caseload								Serial Abuse							
	Child Remain Home With Services		Emergency Removal		Petition Temporary Removal		Informal Placement		Child Remain Home With Services		Emergency Removal		Petition Temporary Removal		Informal Placement	
Male	41	34.4 (44.6)	20	16.8 (41.7)	51	42.9 (55.4)	7	5.9 (46.7)	22	37.3 (47.8)	7	11.9 (36.8)	26	44.0 (65.0)	4	6.8 (57.1)
Female	51	39.8 (55.4)	28	21.9 (58.3)	41	32.0 (44.6)	8	6.3 (53.3)	24	45.3 (52.2)	12	22.6 (63.2)	14	26.4 (35.0)	3	5.7 (42.9)
Total	92	37.2	48	19.4	92	37.2	15	6.2	46	41.0	19	17.0	40	35.7	7	6.3

Sex	Isolated Incident							
	Child Remain Home With Services		Emergency Removal		Petition Temporary Removal		Informal Placement	
Male	19	31.7 (41.3)	13	21.7 (44.8)	25	41.7 (48.1)	3	5.0 (37.5)
Female	27	36.0 (58.7)	16	21.3 (55.2)	27	36.0 (51.9)	5	6.7 (62.5)
Total	46	34.1	29	21.5	52	38.5	8	5.9

Race and Selected Dispositions

In the total caseload, black children (42.6 percent) were more likely than white children (34.8 percent) allowed to remain in the home with services. There was little difference between the percent of white and black children who were removed on an emergency basis and who had petitions for temporary removal filed for them.

Agency disposition by race, however, presented a different picture when the nature of the case was considered. More "lenient" dispositions were rendered for black children than white children among the serial abuse cases. The reverse was observed among the isolated incident cases.

Just under sixty percent of the black children among serial abuse cases were allowed to remain in the home with services. This compares to only 33.7 percent of the white children. A high of 21.7 percent of the white children and a low of 7.4 percent of the black children were removed on an emergency basis. Similarly, the disposition of petitioning for temporary removal was made in 39.8 percent of the cases of white children and in 25.9 percent of those of black children.

Among isolated incident cases, approximately thirty-five percent of the white children as compared to approximately twenty-five percent of the black children remained in the home with services. Emergency removal was effected in 29.6 percent of the cases involving black children in comparison to 19.8 percent of those involving white children. The decision to petition for temporary removal was made in regard to 44.4 percent of the black children and 36.6 percent of the white children. See Table 4-4 for these data.

Previous Placement and Dispositions

The issues relevant to the following discussion are applicable to serial abuse cases only since there were no recorded prior incidents or agency actions in isolated incident cases.

Of considerable interest in noting agency disposition for those children who had and those who had not been previously placed for abuse and/or neglect is the apparent lack of difference in the percent of the children allowed to remain in the home with services. One-third of the children who had been previously placed and 34.2 percent of those having no placement history remained in the home.

Of equal interest was the decision on emergency removal. Only 5.6 percent of those children who had been previously placed in comparison to 15.8 percent of those who had never been removed from the home were removed on an emergency basis.

There was little difference between the percent of the previously placed and the never placed for whom the decision was made to petition for temporary removal. Expectedly, however, a petition for permanent removal was filed on a higher percent of the previously placed children (11.1 percent); this compares to only 1.7 percent of those having no placement history.

Of further interest was the tendency for CES personnel not to allow children in serial abuse cases to remain in the home without services. These findings are presented in Table 4-5.

Family Circumstances and Selected Dispositions

Each family was characterized by more than one circumstance; however, Table 4-6 is a presentation based on an analysis by single circumstances.

Among serial abuse cases, the highest percent of children were returned home when the female parent lived with a man, there were too many children, and the child evidenced physical problems. Children in families in which these circumstances were present were quite unlikely to be removed on an emergency basis and to have petitions filed on their behalf. Children were least likely returned to the home when the parent(s) evidenced emotional/psychological problems, and one or both parents evidenced little love for the child.

Among the isolated incident cases, we determined a different distribution. In cases in which the female parent lived with a man, there were too many children, and the mother evidenced little love for the child, a small percent of the children were returned to the home. The highest percent were returned when parents evidenced intellectual problems or physical problems and the child evidenced physical problems.

Seriousness of Harm and Dispositions

If severity of harm serves as a guide to agency dispositions, there appeared to be some problems in the decision-making process. There was minimal difference between the percent of the children not seriously harmed and the percent of the seriously harmed who were allowed to remain in the

TABLE 4-4

Race and Selected Agency Dispositions by Nature of Case

Race	Agency Disposition															
	Total Caseload								Serial Abuse							
	Child Remain Home with Services		Emergency Removal		Petition Temporary Removal		Informal Placement		Child Remain Home with Services		Emergency Removal		Petition Temporary Removal		Informal Placement	
White	64	34.8 (73.6)	38	20.7 (79.2)	70	38.0 (78.7)	12	6.5 (85.7)	28	33.7 (63.6)	18	21.7 (90.0)	33	39.8 (82.5)	4	4.8 (66.7)
Black	23	42.6 (26.4)	10	18.5 (20.8)	19	35.2 (21.3)	2	3.7 (14.3)	16	59.3 (36.4)	2	7.4 (10.0)	7	25.9 (17.5)	2	7.4 (33.3)
Total	87	36.6	48	20.1	89	37.4	14	5.9	44	40.0	20	18.2	40	36.4	6	5.5

Race	Isolated Incident							
	Child Remain Home with Services		Emergency Removal		Petition Temporary Removal		Informal Placement	
White	36	35.6 (83.7)	20	19.8 (71.4)	37	36.6 (75.5)	8	7.9 (100.0)
Black	7	20.9 (16.3)	8	29.6 (28.6)	12	44.4 (24.5)	0	--
Total	43	33.6	28	21.9	49	38.3	8	6.2

TABLE 4-5

Previous Placement and Agency Dispositions

Agency Decision	Previously Placed?				Total
	Yes		No		
	No.	%	No.	%	
In home without services	0	--	0	--	0
In home with services	6	12.8 (33.3)	41	87.2 (34.2)	47
Emergency Removal of Child	1	5.0 (5.6)	19	95.0 (15.8)	20
Emergency removal of other children	0	--	10	100.0 (8.3)	10
Petition for temporary removal of child	6	15.0 (33.3)	34	85.0 (28.3)	40
Petition for temporary removal of children	1	10.0 (5.6)	9	90.0 (7.5)	10
Petition for permanent removal of child	2	50.0 (11.1)	2	50.0 (1.7)	4
Petition for permanent removal of other children	0	--	0	--	0
Informal placement	2	28.6 (11.1)	5	71.4 (4.2)	7
Total	18		120		138

TABLE 4-6

Agency's Selected Dispositions by Circumstances Present and the Nature of the Case

Circumstances	Percent of Selected Dispositions When Circumstance Was Present					
	In Home With Services		Emergency Removal		Petition Temporary	
	Serial	Isolated	Serial	Isolated	Serial	Isolated
Parent(s) evidence intellectual problems	37.8	27.7	13.5	21.3	27.0	34.0
Mother--sexual, drug, alcohol	37.9	19.7	13.8	19.7	25.3	39.4
Parent(s) evidence emotional/psychological problems	25.0	20.2	17.7	20.2	33.3	40.4
Father--sexual, drug, alcohol	30.5	15.6	16.9	17.8	27.1	31.1
Parent(s) evidence physical problems/ illness	32.1	25.7	10.7	17.1	35.7	28.6
History of abuse to child	34.9	20.0	14.7	18.5	29.4	33.8
Parent(s) experiencing marital problems	28.1	19.0	15.6	15.9	32.8	34.9
Temporary financial problems	33.8	16.4	9.9	23.6	31.0	30.9
Low subsistence level	36.7	21.6	14.7	19.3	25.7	35.2
Chronic neglect	32.2	20.8	13.3	17.0	30.0	39.6
Mother--little love for child	24.4	8.8	17.8	11.8	33.3	55.9
Father--little love for child	22.6	18.5	25.8	14.8	29.0	44.4
Child evidences intellectual problems	30.0	33.3	20.0	13.3	23.3	46.7
Child evidences emotional/psychological problems	27.1	25.0	16.7	17.5	31.3	42.5
Child exhibits atypical behaviors	31.6	14.3	15.8	21.4	36.8	50.0
Child evidences physical problems	40.0	25.8	12.0	25.8	32.0	32.3
Parent single living with man	53.3	12.5	6.7	29.2	20.0	37.5
Too many children	42.4	10.9	10.6	21.7	19.7	28.3

home with services, who were removed on an emergency basis, and for which the disposition to petition for temporary removal was made.

Among serial abuse cases, 34.6 percent of the children who were not seriously harmed and 31.1 percent of the seriously harmed remained in the home with services. In approximately fifteen percent of both types of cases, emergency removal was effected. The decision to petition for temporary removal was made in 26.9 percent of the cases of children who were not seriously harmed and in 31.1 percent of those involving serious harm. A petition for permanent removal was filed for 5.1 percent of the non-serious cases.

More distinctions between the two groups of children appeared in the dispositions in regard to seriousness of harm among isolated incident cases. In slightly more than thirty percent of the non-serious cases and slightly less than twenty-five percent of the serious cases, the decision to allow the children to remain in the home with services was made. Similarly, in less than fifteen percent of the non-serious cases and just under twenty-five percent of the serious cases, emergency removal was effected. The decision to petition for temporary removal was made in 28.1 percent of the non-serious cases and in 34.8 percent of the serious cases.

The complete distribution of agency dispositions by seriousness of harm and the nature of the case appears in Table 4-7.

Petitions Filed and Foster Home Placement

A petition for removal was filed in slightly more than fifty percent of the serial abuse and the isolated incident cases. The case was heard and a decision rendered in more than ninety percent of both types of cases.

Noting the total caseload in Table 4-8, petitions were most likely filed on the two oldest groups of children; however, there were some major differences to this general finding when we considered the nature of the case. Among serial abuse cases a petition was filed in a higher percent of cases involving children under the age of three than any other age group. Well over sixty percent of these children had a petition filed on their behalf. A petition was filed for 60.0 percent of the children age fourteen to less than eighteen and for 56.5 percent of those age six to less than ten. A petition was filed in only a third of the cases involving children between age three and six.

Children between ten and fourteen were the most likely group among isolated incident cases to have a petition filed on their behalf. A petition was filed in over ninety percent of the cases involving this age group. This compares to 56.2 percent of the cases involving children fourteen and over and less than fifty percent involving children in the other age categories.

While a petition for removal was filed on a higher percent of the oldest children in the total caseload, they were the least likely to go into foster care. Of a total of 21 children between ten and fourteen on whom a petition was filed only 6 or 28.6 percent went into foster care; 4 or 22.2 percent of the fourteen and over were placed in foster homes. Children under three years of age (53.7 percent) and those between the age of six and ten (60.0 percent) were the most likely groups placed in foster homes. Basically, this pattern persisted when the nature of the case was considered. See Table 4-8 for data relevant to the above discussion.

With regard to race, a petition for removal was filed on a higher percent of the white children among serial abuse cases than the percent of the black children. According to Table 4-9, 61.9 percent of the white children and 35.7 percent of the black had petitions filed on their behalf. The reverse was found in the isolated incident caseload; a petition was filed on 49.4 percent of the white and 66.7 percent of the black.

Unexpectedly, a slightly higher percent of the black children on whom petitions were filed were placed in foster care. Among serial abuse cases, 47.7 percent of the white children and 50.0 percent of the black were placed in foster homes. In the isolated incident caseload, 36.4 percent of the white and 43.8 percent of the black were placed in foster homes. Analyzing the data from a different perspective, 28.4 percent of all the white children in the serial abuse caseload and 17.9 percent of all the black children were placed in foster care. The reverse was observed for the isolated incident caseload; 17.2 percent of the white and 29.2 percent of the black were placed in foster care.

Regarding sex and the filing of petitions for removal, there was little difference between the percent of males (52.8 percent) and the percent of females (53.1 percent) among serial abuse cases on whom a petition was filed. A petition was filed on a slightly higher percent of the males among isolated incident cases than the percent of females--55.4 and 50.0, respectively.

TABLE 4-7

Seriousness of Harm and Agency Dispositions

Agency Decisions	Serial Abuse Cases						Isolated Incident Cases						Total Caseload					
	Not Serious		Serious		Unknown		Not Serious		Serious		Unknown		Not Serious		Serious		Unknown	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
In home without services	0	--	0	--	0	--	5	71.4 (5.6)	1	14.3 (1.5)	1	14.3 (7.1)	5	71.4 (3.0)	1	14.3 (0.9)	1	14.3 (3.4)
In home with services	27	57.4 (34.6)	14	29.8 (31.1)	6	12.8 (40.0)	27	57.4 (30.3)	16	34.0 (24.2)	4	8.5 (28.6)	54	57.4 (32.3)	30	31.9 (27.0)	10	10.6 (34.5)
Emergency removal of child	12	60.0 (15.4)	7	35.0 (15.6)	1	5.0 (6.7)	12	40.0 (13.5)	16	53.3 (24.2)	2	6.7 (14.3)	24	48.0 (14.4)	23	46.0 (20.7)	3	6.0 (10.3)
Emergency removal of other children	5	50.0 (6.4)	4	40.0 (8.9)	1	10.0 (6.7)	5	55.6 (5.6)	4	44.4 (6.1)	0	--	10	52.6 (6.0)	8	42.1 (7.2)	1	5.3 (3.4)
Petition for temporary removal of child	21	52.5 (26.9)	14	35.0 (31.1)	5	12.5 (33.3)	25	47.2 (28.1)	23	43.4 (34.8)	5	9.4 (35.7)	46	49.5 (27.5)	37	39.8 (33.3)	10	10.8 (34.5)
Petition for temporary removal other children	4	40.0 (5.1)	5	50.0 (11.1)	1	10.0 (6.7)	7	63.6 (7.9)	3	27.3 (4.5)	1	9.1 (7.1)	11	52.3 (6.6)	8	38.1 (7.2)	2	9.5 (6.9)
Petition for permanent removal of child	4	100.0 (5.1)	0	--	0	--	1	50.0 (1.1)	0	--	1	50.0 (7.1)	5	83.3 (3.0)	0	--	1	16.7 (3.4)
Petition for permanent removal of other children	0	--	0	--	0	--	1	100.0 (1.1)	0	--	0	--	1	100.0 (0.6)	0	--	0	--
Informal placement	5	71.4 (6.4)	1	14.3 (2.2)	1	14.3 (6.7)	6	66.7 (6.7)	3	33.3 (4.5)	0	--	11	68.8 (6.6)	4	25.0 (3.6)	1	6.3 (3.4)
Total	78		45		15		89		66		14		167		111		29	

TABLE 4-8

Petitions Filed and Foster Home Placement by Age and Nature of the Case

Age	Petition Filed?												Foster Home Placement*					
	Serial Abuse				Isolated Incident				Total Caseload				Serial Abuse		Isolated Incident		Total Caseload	
	Yes		No		Yes		No		Yes		No							
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
< 3	16	66.7	8	33.3	25	47.1	28	52.9	41	53.2	36	46.8	9	36.4 (56.2)	13	23.2 (52.0)	22	27.0 (53.7)
3< 6	8	33.3	16	66.7	10	47.6	11	52.4	16	40.0	27	60.0	4	16.0 (50.0)	3	14.3 (30.0)	7	15.2 (38.9)
6<10	13	56.5	10	43.5	7	36.9	12	63.1	20	47.6	22	52.4	8	34.8 (61.5)	4	20.0 (57.1)	12	28.6 (60.0)
10<14	8	47.1	9	52.9	13	92.9	1	7.1	21	66.7	10	32.3	3	17.6 (37.5)	3	21.4 (23.1)	6	19.4 (28.6)
14<18	9	60.0	6	40.0	9	56.2	7	43.8	18	58.1	13	41.9	2	12.5 (22.2)	2	12.5 (22.2)	4	12.5 (22.2)
Total	54	52.4	49	47.6	64	52.0	59	48.0	118	52.2	108	47.8	26		25		51	

*Percentages within brackets are based on the number of children in placement as a percent of children on whom petitions were filed. Other percentages are based on the number of children in foster home placement as a percent of the total number of children in each age category.

TABLE 4-9

Petitions Filed and Foster Home Placement by Race and Nature of the Case

Race	Petition Filed?												Foster Home Placement*					
	Serial Abuse Yes		Serial Abuse No		Isolated Incident Yes		Isolated Incident No		Total Caseload Yes		Total Caseload No		Serial Abuse		Isolated Incident		Total Caseload	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	44	61.9	27	38.1	44	49.4	45	50.6	88	55.0	72	45.0	21	28.4 (47.7)	16	17.2 (36.4)	37	22.2 (42.0)
Black	10	35.7	18	64.3	16	66.7	8	33.3	26	50.0	26	50.0	5	17.9 (50.0)	7	29.2 (43.8)	12	23.1 (46.1)
Total	54	54.5	45	45.5	60	53.1	53	46.9	114	53.8	98	46.2	26		23		49	

*Percentages within brackets are based on the number of children in placement as a percent of children on whom petitions were filed. Other percentages are based on the number of children in foster home placement as a percent of the total number of children of each race.

While petitions were filed on a higher percent of the males, a slightly higher percent of the females were placed in foster care. In considering the data by the nature of the case, however, we found that males among serial abuse cases were more likely than females to be placed in foster homes. On the other hand, females among the isolated incident cases were more likely to be placed in foster homes. See Table 4-10 for these data.

Dispositions in Cases Entering the Court*

We noted in the previous discussions that 51 of the children in the total caseload were placed in foster homes. The data in Table 4-11 reveal that foster home placements represented slightly less than fifty percent of the dispositions made. There were some differences when the nature of the case was considered. Children among serial abuse cases (48.1 percent) were more likely than children among isolated incident cases (39.7 percent) to be placed in foster homes.

The evidence suggests that the court was more willing to give situations a "second chance" in isolated incident cases than in serial abuse cases. Only 16.7 percent of the children among serial abuse cases were returned to one or both parents. This compares to 23.7 percent of the children in the isolated incident caseload.

Previous Placement and Selected Court Dispositions

Whether or not a child had been previously placed seemed to have influenced the court's decision in the current incident of the serial abuse cases. None of the children who had a placement history was returned to one or both parents in comparison to approximately twenty percent of those who had not been previously placed.

The agency was more likely to place children with a placement history with other relatives and in a voluntary care institution than those who had not been previously placed.

Seriousness of Harm and Selected Court Dispositions

Among isolated incident cases a higher percent of the seriously harmed children were placed with a parent (33.0 percent) than the percent of those seriously harmed in the serial abuse caseload (13.4 percent). The same pattern held for the cases involving non-serious harm; 28.6 percent of the children among the isolated incident cases as compared to 17.9 percent of those among the serial abuse cases were placed with a parent.

Viewing disposition from the perspective of out-of-the-family, including placement with a relative other than the parent(s), we found differences between the categories of seriousness of harm in only the isolated incident cases. Among isolated incident cases, only 39.3 percent of the children who were not seriously harmed in comparison to 64.0 percent of the seriously harmed were placed out-of-the-family. While a higher percent of the children in the serial abuse caseload were placed out-of-the-family, there appeared to be little distinction when seriousness of harm was considered. Slightly over seventy percent of the children who were not seriously harmed and 67.7 percent of the seriously harmed were placed out-of-the-family. Thus, it appears that the decision in these kinds of placements was influenced more by the fact that the children had been previously harmed than by the severity of harm suffered. These data are presented in Table 4-12.

Family Circumstances and Selected Court Dispositions

What are the circumstances present in families where children are returned by the court to their own home? Without controlling for race, we attempted very elementary analyses of court's decisions in relation to family circumstances.

We found that children were more likely returned to the home in cases where child related personal circumstances/conditions were present. For the total caseload and the isolated incident cases, the highest percentage of children returned to the parent(s) were those in which the child evidenced intellectual problems, the child exhibited atypical behaviors, and the parents were experiencing marital problems, in that order. This pattern, however, was not observed for the serial abuse caseload. A higher percent of the children were returned in cases in which the circumstances of father's sexual, drug, and/or alcoholic behavior, history of abuse, and child evidenced intellectual problems were present.

When we noted the cases in which children were least likely placed with the parent(s), we found that parental problems/behaviors were more apparent circumstances. Children were least likely to be returned to families in which the parents evidenced physical problems/illnesses, where there was

*In both systems, the court made the disposition to return or not to return children to their own homes. Some few court decrees included protective surpervision, continuation, and/or general services. Beyond this, the protective service agency was responsible for placement upon receiving custody of cases.

TABLE 4-10

Petitions Filed and Foster Home Placement by Sex and Nature of the Case

Sex	Petition Filed?												Foster Home Placement*					
	Serial Abuse				Isolated Incident				Total Caseload				Serial Abuse		Isolated Incident		Total Caseload	
	Yes		No		Yes		No		Yes		No							
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Male	28	52.8	25	47.2	31	55.4	25	44.6	59	54.1	50	45.9	15	28.3 (53.6)	10	17.2 (32.3)	25	22.9 (42.4)
Female	26	53.1	23	46.9	32	50.0	32	50.0	58	51.3	55	48.7	11	21.6 (42.3)	15	22.7 (46.9)	26	23.0 (44.8)
Total	54	52.9	48	47.1	63	52.5	57	47.5	117	52.7	105	47.3	26		25		51	

*Percentages within brackets are based on the number of children in placement as a percent of children on whom petitions were filed. Other percentages are based on the number of children in foster home placement as a percent of the total number of each sex.

TABLE 4-11

Disposition in Cases Entering the Court
by the Nature of the Case

Dispositions	Serial Abuse			Isolated Incident		
	No.	Percent of Children (N=54)*	Percent of Dispositions	No.	Percent of Children (N=63)*	Percent of Dispositions
Placed with both parents	4	7.4	6.7	2	3.1	2.6
Placed with mother	3	5.6	5.0	11	17.5	14.3
Placed with father	2	3.7	3.3	2	3.1	2.6
Placed with other relative	7	13.0	11.7	12	19.0	15.6
Foster home	26	48.1	43.3	25	39.7	32.5
Voluntary care institution	7	13.0	11.7	7	11.1	9.1
State long term care institution	1	1.9	1.7	2	3.1	2.6
Continuation	4	7.4	6.7	0	--	--
**Protective supervision	2	3.7	3.3	13	20.6	16.9
General services	4	7.4	6.7	2	3.1	2.6
No services	0	--	--	1	1.6	1.2

*Percentages add up to an excess of 100 since more than one disposition was made in some cases.

**This is probably a conservative representation of this court ordered disposition inasmuch as the order was not explicitly stated in the court decree in many cases.

TABLE 4-12

Disposition in Cases Entering the Court by Seriousness of Harm

Court Decisions	Total Caseload						Serial Abuse						Isolated Incident					
	Not Serious		Serious		Unknown		Not Serious		Serious		Unknown		Not Serious		Serious		Unknown	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Returned to both parents	5	83.7 (8.9)	1	16.3 (2.5)	0	--	3	75.0 (10.7)	1	25.0 (6.7)	0	--	2	100.0 (7.1)	0	--	0	--
Placed with mother	6	42.9 (10.7)	7	50.0 (17.5)	1	7.1 (8.3)	1	33.3 (3.6)	1	33.3 (6.7)	1	33.3 (16.7)	5	45.5 (17.9)	6	54.5 (29.0)	0	--
Placed with father	2	50.0 (3.6)	1	25.0 (2.5)	1	25.0 (8.3)	1	50.0 (3.6)	0	--	1	50.0 (16.7)	1	50.0 (3.6)	1	50.0 (4.0)	0	--
Placed with other relatives	12	63.2 (21.4)	5	26.3 (12.5)	2	10.5 (16.7)	3	42.9 (10.7)	3	42.9 (20.0)	1	14.3 (16.7)	9	75.0 (32.1)	2	16.7 (8.0)	1	8.3 (16.7)
Foster home	22	43.1 (39.3)	21	41.2 (53.5)	8	15.7 (66.7)	14	53.8 (50.0)	9	34.6 (60.0)	3	11.5 (50.0)	8	32.0 (28.6)	12	48.0 (48.0)	5	20.0 (83.3)
Voluntary care institutions	9	64.3 (16.1)	5	35.7 (12.5)	0	--	6	85.7 (21.4)	1	14.3 (6.7)	0	--	3	42.9 (10.7)	4	57.1 (16.0)	0	--
Total	56		40		12		28		15		6		28		25		6	

chronic neglect, and the father exhibited little love for the child. See Table 4-13 for the slight differences in the pattern by the types of cases.

Thinking back on the seriousness of harm by the presence of circumstances, the above pattern to the court's dispositions causes some basis for concern. We have just noted that a higher percent of children were returned to the home when child-related circumstances were present. These were among the very types of circumstances in which a high percent of the cases were of a serious nature. Conversely, while the court returned a small percentage of the children to their homes where chronic neglect and parents evidenced physical problems were present circumstances, there was a tendency for a relatively small percent of the children to be seriously harmed when these circumstances were present. This was particularly of note for the serial abuse cases.

Beyond the findings represented by the above discussion, we attempt to make no conclusive statements. It would appear, however, that more research and extensive analyses need to address these, as well as other circumstances, toward the goal of identifying relevant criteria for judges in the adjudicatory and dispositional processes in child abuse and neglect cases.*

Services Rendered

Beyond the investigation and "on the spot" counseling which generally consisted of admonitions, no services were provided to over ten percent of the children and parents in the serial abuse caseload and to over fifteen percent of those among the isolated incident cases.

An array of services was provided to children and their families who entered the CES system and became a part of their on-going caseload. These services which are presented in Table 4-14 will be discussed in groups--those rendered to a few children and families, those rendered to approximately the same percentage of children and families in both types of cases, and those more likely rendered in one or the other type caseload.

Limited Services Rendered.--Of current interest in the child abuse and neglect area is the issue of legal representation for every child who goes before the court in an abuse and/or neglect case. These specific kinds of services were rendered to a very small percent of the children. We noted earlier that a petition for removal was filed and the case heard by the court in approximately one half of the total caseload. However, none of the children among serial abuse cases and only 1.6 percent of those among isolated incident cases were represented by a legal authority. On the other hand, 3.8 and 3.9 percent of the parents of children in the two types of cases were referred for legal services.

Children who are abused and/or neglected often have limited access to the cultural and social outlets germane to normal childhood growth and development. By the same token, many experts characterize parents of these children as being virtually social isolates. This being an accepted "fact," it is surprising that services directed toward the cultural and/or recreational needs were not provided to any children or parents among the serial abuse cases; in only 0.8 percent of the isolated incident cases were such services offered to the abused or neglected children.

While homemakers were assigned in a relatively high percent of both types of cases, we were not able to find supporting evidence which suggested that tutorial services and instruction in food preparation were services rendered in many cases. This would suggest that while homemakers provided normal household chores, they may not have been instrumental in transmitting the "how-to-skills" to the parents. Again, we must emphasize the major limitation in interpreting these data--while project personnel thoroughly assessed the recorded case data, we could not assess data, e.g., homemaker's and/or caseworkers' behaviors which were not a part of the record.

An accepted given is that abuse and neglect are symptoms of other problems. One such problematic area could well be that of the whole family interactional pattern, i.e., parent-parent-child. Yet, counseling around such areas were minimal services rendered.

Services Rendered in Similar Percent of Cases in Both Caseloads.--CES personnel availed themselves of community resources through referrals. Approximately twenty percent of the children among both types of cases were referred for psychological and/or psychiatric services. Just under thirty percent of the parents of these children were also referred for these kinds of services. Slightly less than one-third of

*These observations have simply been made and presented. We are not postulating that any one circumstance is a better criterion. One major factor necessitates this position: the percentages are based on single circumstances, while several were present in each case. Beyond this, other factors, e.g., judges orientation, presence/absence of legal representatives, obviously were in operation.

TABLE 4-13

Court's Return of Children to the Home by Circumstances Present and the Nature of the Case

Circumstances	No. of Cases in which Circumstances was Present	Percent of Children Returned when Circumstance was Present
Serial Abuse		
Father's sexual, alcohol, drug problems	18	22.3
History of abuse	39	20.5
Child evidences intellectual problems	10	20.0
Parents evidence physical problem/illness	9	0.0
Chronic neglect	29	6.8
Mother's sexual, alcohol, drug problems	28	7.2
Isolated Incident		
Child evidences intellectual problems	7	28.6
Child exhibits behavioral atypicalities	14	28.5
Parents experiencing marital problems	25	28.0
Chronic neglect	23	4.3
Family at a low subsistence level	33	6.0
Father shows little love for child	14	7.1
Total Caseload		
Child evidences intellectual problems	17	23.6
Child exhibits behavioral atypicalities	22	22.6
Parents experiencing marital problems	47	21.3
Parents evidence physical problems/illness	20	5.0
Chronic neglect	52	5.7
Father shows little love for child	24	8.4

TABLE 4-14

Services Rendered by Nature of the Case

Services Rendered	Serial Abuse		Isolated Incident	
	N	%	N	%
No services to child	11	10.4	22	17.3
No services to parent(s)	14	13.2	25	19.7
Referral mental services--child	22	20.8	24	18.9
Referral physical services--child	35	33.0	37	29.1
Referral legal services--child	0	--	2	1.6
Referral mental services--parent(s)	30	28.3	35	27.6
Referral physical services--parent(s)	21	19.8	15	11.8
Referral legal services--parent(s)	4	3.8	5	3.9
Collection/repair material goods	13	12.3	6	4.7
Transportation professional services	10	9.4	6	4.7
Cultural-recreational opportunities--child	0	--	1	0.8
Cultural-recreational opportunities--parent(s)	0	--	0	--
Tutoring/teacher aide/educational opportunities	0	--	2	1.6
Instruction in food preparation	2	1.9	7	5.5
Transportation personal needs	9	8.5	9	7.0
Child care or day care	17	16.0	22	17.2
Supervision of children	5	4.7	2	1.6
Counseling-child development needs, problems	57	53.8	63	49.2
Counseling-child discipline	23	21.7	28	22.0
Counseling-marital problems	14	13.2	19	15.0
Counseling-budgeting	7	6.6	15	11.7
Counseling-parent/child interaction	11	10.4	19	14.8
Counseling-family planning	12	11.3	15	11.7
Counseling-home management	18	17.0	17	13.8
Counseling-parent/parent/child interaction	3	2.8	8	6.3
Counseling-parent development	14	13.2	12	9.4
Counseling-parent view of the world	8	7.5	14	10.9
Counseling-parent role	7	6.6	12	9.4
Counseling with child	3	2.8	14	10.9
Counseling-no special focus determined	10	9.4	8	6.3
Homemaker services	19	17.9	15	11.7
Public financial assistance	32	30.2	29	22.7
Food preparation	2	1.9	4	3.1
General cleaning	4	3.8	6	4.7
Home visitation-protective supervision	70	66.0	83	64.8

Percentages are based on the total number of cases in the caseloads.

the children among the serial abuse cases and a little less than thirty percent of those among the isolated incident cases were referred for physical problems, probably related to the reported incident.

It has been recognized that the availability of child or day care may be a preventive factor to the recurrence of abuse and/or neglect. Such services were provided in 16.0 percent of the serial abuse cases and in 17.2 percent of the isolated incident cases.

Recalling first the types of abuse and secondly family circumstances present in the reported families, it appears that the focus of social work counseling had minimal relevance in certain areas. Neglect due to parental inadequacies was one of the most frequent observed types of abuse. Many of these families were characterized by too many children, chronic neglect, marital problems, and financial hardships. Yet, social work counseling which would appear to be relevant to such familial circumstances was rendered in a relatively small percentage of the cases. Counseling on marital problems was a service rendered in 13.2 percent of the serial abuse cases and in 15.0 percent of the isolated incident cases. Parent-child interaction was the focus of counseling in 10.4 percent of the serial abuse cases and in 14.8 percent of the isolated incident case. Home management problems was the basis for social work counseling in 17.0 and 13.8 percent of the serial abuse and the isolated incident cases, respectively. Family planning counseling was an evident service rendered in only 11.3 percent of the serial abuse cases and in 11.7 percent of the isolated incident cases.

Caseworkers counseled with a high percent of the parents among both types of cases on the area of child development, needs, and problems. Such services were rendered in over fifty percent of the serial abuse cases and in just under fifty percent of the siolated incident cases.

Services More Likely in a Particular Type of Caseload.-- It appears that services of a tangible nature were more likely rendered to families in the serial abuse caseload. Referral of parents for physical services was made in 19.8 percent of the serial abuse cases and in 11.8 percent of the isolated incident cases.

Previous data presented indicate that families among the serial abuse cases were more likely characterized by financial problems. The nature of services rendered appears to support these findings. The collection and/or repair of material goods was accomplished for 12.3 percent of these families and for only 4.7 percent of the families among the isolated incident cases. Public financial assistance was provided to 30.2 percent and 22.7 percent of the families in the two types of cases, respectively. Beyond this, homemakers were provided to a higher percent of families among the serial abuse caseload.

An important part of the total protective service process would appear to be that of providing appropriate counseling to the child. Such services were provided to 10.9 percent of the children among the isolated incident cases in comparison to only 2.8 percent in the serial abuse caseload.

While a higher percent of the families among the serial abuse cases were known to be experiencing temporary financial problems as well as being at a general low subsistence level, counseling around budgetary matters was more often offered in families among the isolated incident cases--in 6.6 and 11.7 percent, respectively.

Dispositions and Services in the PSU System

Case Dispositions

The disposition made most frequently by caseworkers in the PSU system was that of allowing the child to remain in the home with services. The second and third most frequent dispositions were to file a petition for temporary removal of the child and to file a petition for both the child and other children in the family. Emergency removal was effected in a small percentage of the cases.

There were some differences in agency dispositions by the nature of the case. A slightly higher percent of the children in the isolated incident caseload (63.1 percent) were allowed to remain in the home with services. This compares to 59.4 percent in the serial abuse caseload. Similarly, a higher percent of the isolated incident cases were allowed to remain in the home without services. The disposition to petition for the temporary removal of the child was made in a higher percent of the serial abuse cases. A higher percent of the children in the serial abuse caseload were removed on an emergency basis. Children among the isolated incident cases were more likely informally placed with other relatives.

The complete distribution of agency dispositions is presented in Table 4-15.

TABLE 4-15

Agency Disposition by the Nature of the Case

Case Dispositions	Nature of Case						Total	
	Serial Abuse			Isolated Incident				
	No.	Percent of Children* (N=64)	Percent of Dispositions	No.	Percent of Children* (N=195)	Percent of Dispositions	N	%
Child remain in home without services	2	3.1	2.4	23	11.9	10.0	25	9.7
Child remain in home with services	38	59.4	44.7	123	63.1	53.7	161	62.2
Emergency removal of child	8	12.5	9.4	16	8.2	7.0	24	9.3
Emergency removal of child/other children	4	6.3	4.7	7	3.6	3.0	11	4.2
Petition for temporary removal of child	19	29.7	22.4	34	17.5	14.8	53	20.5
Petition for temporary removal of child/ other children	10	15.6	11.8	16	8.2	8.2	26	10.0
Petition for permanent removal of child	3	4.7	3.5	2	1.0	0.9	5	1.9
Petition for permanent removal child/ other children	0	--	--	1	0.5	0.4	1	0.4
Informal placement with other relative	1	1.6	1.1	7	3.6	3.6	8	3.1

*Percentages add up to more than 100 since more than one disposition was made in some cases.

Age and Selected Dispositions

Among serial abuse cases, children in the oldest age categories were less likely to remain home with services than were younger children–approximately forty percent of the fourteen and older and 46.7 percent of those between the age of ten and fourteen. This compares to a high of 81.8 percent of the children under age three, 50.0 percent of the three to less than six, and 71.4 percent of the children between age six and ten. Similarly, there was a tendency for emergency removal and petitions for temporary removal to be effected in a higher percent of cases involving the two oldest groups of children.

The pattern of agency dispositions differed only slightly for the isolated incident cases. The two oldest groups of children remained the ones least likely allowed to remain in home with services and more likely to have petitions filed for temporary removal in their behalf. Slightly more than fifty percent of the children between age ten and fourteen and 60.9 percent of those fourteen and above were allowed to remain in the home with services. By comparison, the agency's similar disposition affected 72.7 percent of the under three, 66.7 percent of the three to less than six, and 80.0 percent of the six to less than ten. There was minimal difference in the percentage of the youngest (10.6 percent) and the two oldest groups of children (10.3 and 13.0 percent) who were removed on an emergency basis. The children between three and six years of age (3.7 percent) were the least likely removed on an emergency basis. The disposition to petition for temporary removal was made for 31.0 percent of the children age ten to less than fourteen, 26.1 percent of the fourteen and above, and 22.2 percent of those between three and six. On the other hand, this disposition was made in less than fifteen percent of the cases involving children under age three (13.6 percent) and those age six to less than ten (11.4 percent). See Table 4-16 for the distribution of selected dispositions by the age of children.

Sex and Selected Dispositions

According to the data in Table 4-17, there was minimal difference between the sexes in regard to agency dispositions in the total caseload. Major differences were revealed when the nature of the case was considered.

Among serial abuse cases, the decision to allow the child to remain in the home with services was more likely made in cases involving females; 66.7 percent females to 46.7 percent males. Approximately twenty percent of the males as compared to 5.6 percent of the females were removed from the home on an emergency basis. A petition for temporary removal was the disposition in 33.3 percent of the cases involving males and 25.0 percent of those involving females.

While the differences were not pronounced, the pattern was reverse for the isolated incident caseload. A slightly higher percent of the males (69.7 percent) were allowed to remain in the home with services. This compares to 65.9 percent of the females. The disposition of emergency removal was made in 6.7 percent of the cases involving males as compared to 11.4 percent of those in which females were involved. The decision to file a petition for temporary removal was made in approximately twenty percent of the cases involving both males and females.

Race and Selected Dispositions

A disposition which allowed children to remain in the home with services was more likely made in cases involving white children. Black children were more likely removed on an emergency basis and to have a petition for temporary removal filed on their behalf.

In the serial abuse caseload, there was a slight difference in the percent of the white children (61.1 percent) and the percent of the black children (57.1 percent) who remained in the home with services. The decision to petition for temporary removal was made in 30.6 percent of the cases of white children and in 25.0 percent of those of black children. The major difference between the races in regard to agency disposition was centered on emergency removal. Less than six percent of the white children as compared to 17.9 percent of the black were removed on an emergency basis.

In some respects, the differences in the dispositions were more pronounced between the races in the isolated incident caseload. Approximately sixty percent of the black children in comparison to well over seventy percent of the white were allowed to remain in the home with services. The decision on emergency removal was made in 7.8 percent of the cases involving white children and in 10.3 percent of those involving black children. The decision to petition for temporary removal was made in 14.6 percent of the cases in which white children were involved and in 26.5 percent of those involving black children. See Table 4-18.

TABLE 4-16

Age and Selected Agency Dispositions by the Nature of Case

Age	Agency Dispositions															
	Total Caseload				Serial Abuse				Isolated Incident							
	Child Remain Home With Services	Emergency Removal	Petition Temporary Removal	Informal Placement	Child Remain Home With Services	Emergency Removal	Petition Temporary Removal	Informal Placement	Child Remain Home With Services	Emergency Removal	Petition Temporary Removal	Informal Placement				
< 3	57 77.0 (35.4)	8 10.4 (33.3)	10 13.0 (18.9)	2 2.6 (25.0)	9 81.8 (23.7)	1 9.1 (12.5)	1 9.1 (5.3)	0 --	48 72.7 (39.0)	7 10.6 (43.8)	9 13.6 (26.5)	2 3.0 (28.6)				
3< 6	26 60.5 (16.1)	3 7.0 (12.5)	12 27.9 (22.6)	2 4.7 (25.0)	8 50.0 (21.1)	2 12.5 (25.0)	6 37.5 (31.6)	0 --	18 66.7 (14.6)	1 3.7 (6.3)	6 22.2 (17.6)	2 7.4 (28.6)				
6<10	38 77.6 (23.6)	3 6.1 (12.5)	7 14.3 (13.2)	1 2.0 (12.5)	10 71.4 (26.3)	1 7.1 (12.5)	3 21.4 (15.8)	0 --	28 80.0 (22.8)	2 5.7 (12.5)	4 11.4 (11.8)	1 2.9 (14.3)				
10<14	22 50.0 (13.7)	5 11.4 (20.8)	14 31.8 (26.4)	3 6.8 (37.5)	7 46.7 (18.4)	2 13.3 (25.0)	5 33.3 (26.3)	1 6.7 (100.0)	15 51.7 (12.2)	3 10.3 (18.8)	9 31.0 (26.5)	2 6.9 (28.6)				
14<18	18 54.4 (11.2)	5 15.2 (20.8)	10 30.3 (18.9)	0 --	4 40.0 (10.5)	2 20.0 (25.0)	4 40.0 (21.1)	0 --	14 60.9 (11.4)	3 13.0 (18.8)	6 26.1 (17.6)	0 --				
	161 65.4	24 9.8	53 21.5	8 3.3	38 57.6	8 12.1	19 28.8	1 1.5	123 68.3	16 8.9	34 18.9	7 3.9				

TABLE 4-17

Sex and Selected Agency Dispositions by Nature of Case

Sex	Agency Dispositions															
	Total Caseload								Serial Abuse							
	Child Remain Home With Services		Emergency Removal		Petition Temporary Removal		Informal Placement		Child Remain Home With Services		Emergency Removal		Petition Temporary Removal		Informal Placement	
Male	76	63.9 (48.1)	12	10.1 (50.0)	27	22.7 (50.9)	4	3.4 (50.0)	14	46.7 (36.8)	6	20.0 (75.0)	10	33.3 (52.6)	0	--
Female	82	66.1 (51.9)	12	9.7 (50.0)	26	21.0 (49.1)	4	3.2 (50.0)	24	66.7 (63.2)	2	5.6 (25.0)	9	25.0 (47.4)	1	2.8 (100.0)
Total	158	65.0	24	9.9	53	21.8	8	3.3	38	57.6	8	12.1	19	28.8	1	1.5

Sex	Agency Dispositions							
	Isolated Incident							
	Child Remain Home With Services		Emergency Removal		Petition Temporary Removal		Informal Placement	
Male	62	69.7 (51.7)	6	6.7 (37.5)	17	19.1 (50.0)	4	4.5 (57.1)
Female	58	65.9 (48.3)	10	11.4 (62.5)	17	19.3 (50.0)	3	3.4 (42.9)
Total	120	67.8	16	9.0	34	19.2	7	4.0

TABLE 4-18

Race and Selected Agency Dispositions by Nature of Case

Race	Agency Disposition															
	Total Caseload				Serial Abuse				Isolated Incident			
	Child Remain Home with Services	Emergency Removal	Petition Temporary Removal	Informal Placement	Child Remain Home with Services	Emergency Removal	Petition Temporary Removal	Informal Placement	Child Remain Home with Services	Emergency Removal	Petition Temporary Removal	Informal Placement
White	98 70.5 (63.2)	10 7.2 (45.5)	26 18.7 (51.0)	5 3.6 (71.4)	22 61.1 (57.9)	2 5.6 (28.6)	11 30.6 (61.1)	1 2.8 (100.0)	76 73.8 (65.0)	8 7.8 (53.3)	15 14.6 (45.5)	4 3.9 (66.7)
Black	57 59.4 (46.8)	12 12.5 (54.5)	25 26.0 (49.0)	2 2.1 (28.6)	16 57.1 (42.1)	5 17.9 (71.4)	7 25.0 (38.9)	0 --	41 60.3 (35.0)	7 10.3 (46.7)	18 26.5 (54.5)	2 2.9 (33.3)
Total	155 66.0	22 9.4	51 21.7	7 3.0	38 59.4	7 10.9	18 28.1	1 1.6	117 68.4	15 8.8	33 19.3	6 3.5

Previous Placement and Dispositions

Previous placement of the child seemed to have influenced the agency's disposition following the most currently reported incident. Only 23.3 percent of the children with a placement history in comparison to 55.6 percent of those who had not been previously placed were allowed to remain in the home with services. Emergency removal of the child was the disposition made in 13.3 percent of the cases involving previous placement of the child; this compares to only 7.4 percent of those without a placement history.

The disposition to petition for temporary removal was made in 26.7 percent of the cases of previously placed and in 20.4 percent of those in which the children had not been previously placed. Of interest, however, was the agency's tendency toward the filing of a petition on siblings of the reported child among the cases of children involved in previous placements. The disposition to file a petition on behalf of the child and other children in the family was made in 20.0 percent of the previous placement history cases. This compares to this disposition being made in only 7.4 percent of the cases in which prior placement was not a factor.

See Table 4-19 for the complete distribution of agency dispositions in relation to placement history.

Family Circumstances and Selected Dispositions

In serial abuse cases involving children with child-related personal problems and the deviant behavior of the father, the disposition to allow the child to remain in the home was least likely made. The highest percent of children were allowed to remain in the home when there were too many children and the family's financial circumstances were low.

This pattern did not hold in the isolated incident caseload. A high percent of children with child-related personal problems and of parents who evidenced intellectual problems remained in the home. The lowest percent of children remained home where one or both of the parent's love for the child was in question. These findings appear in Table 4-20.

Seriousness of Harm and Dispositions

According to the findings presented in Table 4-21, seriousness of harm suffered by the children appeared to have been a criterion the PSU caseworkers employed in making case dispositions.

Among the serial abuse cases, 53.1 percent of the cases involving non-serious harm to the children and only 25.8 percent of those involving serious harm were allowed to remain in the home with services. A disposition for emergency removal of the child was made on 12.9 percent of the cases in which children were seriously harmed. This compares to only 6.1 percent of the cases in which the harm was determined not to be serious.

We noted earlier that the decision to petition for temporary removal was made in just under thirty percent of the serial abuse cases. However, when noting this disposition by seriousness of harm, we found this disposition to apply to less than twenty percent of the non-serious cases in comparison to approximately one-third of the serious cases. Similarly, out-of-the-home placement dispositions for other children in the family were more likely made in cases involving serious harm to the reported child.

The pattern noted in the serial abuse caseload was also observed in the isolated incident caseload with the distinctions between dispositions made in cases by seriousness being more pronounced.

Petitions Filed and Foster Home Placement

A petition for removal of the child was filed in one-third of the serial abuse cases and approximately twenty percent of the isolated incident cases. The case was heard and a court decision rendered in just under one hundred percent of the cases on which a petition was filed.

Noting the data in Table 4-22, petitions were more likely filed on children in the two oldest age categories. This pattern was found to maintain when the nature of the case was considered.

Among the serial abuse cases, a petition was filed in 50.0 percent of the cases involving children fourteen and older and in 41.7 percent of those in which the children were between the age of ten and fourteen. A petition was filed on 40.0 percent of the children age three to less than six. The youngest children were the least likely to have a petition filed in their behalf (22.2 percent). A petition was filed in slightly more than one-fourth of the cases involving children between six and ten years of age.

Well over thirty-five percent of the children in the two oldest age groupings in the isolated incident caseload had petitions filed on them. A petition was filed on the behalf

TABLE 4-19

Previous Placement and Agency Dispositions

Agency Decision	Previously Placed?				Total
	Yes		No		
	No.	%	No.	%	
In home without services	0	--	2	100.0 (3.7)	2
In home with services	7	18.9 (23.3)	30	81.1 (55.6)	37
Emergency removal of child	4	50.0 (13.3)	4	50.0 (7.4)	8
Emergency removal of other children	3	75.0 (10.0)	1	25.0 (1.9)	4
Petition for temporary removal of child	8	42.1 (26.7)	11	57.9 (20.4)	19
Petition for temporary removal of children	6	60.0 (20.0)	4	4.0 (7.4)	10
Petition for permanent removal of child	2	66.7 (6.7)	1	33.3 (1.9)	3
Petition for permanent removal of other children	0	--	0	--	0
Informal placement	0	--	1	100.0 (1.9)	1
Total	30		54		84

TABLE 4-20

Agency's Selected Dispositions by Circumstances Present and the Nature of the Case

Circumstances	Percent of Selected Dispositions When Circumstance Was Present					
	In Home With Services		Emergency Removal		Petition Temporary	
	Serial	Isolated	Serial	Isolated	Serial	Isolated
Parent(s) evidence intellectual problems	34.5	57.5	13.8	7.5	20.7	15.0
Mother--sexual, drug, alcohol	40.7	40.6	11.1	11.5	24.1	22.9
Parent(s) evidence emotional/psychological problems	37.9	44.5	10.6	8.9	25.8	18.5
Father--sexual, drug, alcohol	20.8	40.3	12.5	9.0	37.5	19.4
Parent(s) evidence physical problems/ illness	40.0	58.3	6.7	8.3	26.7	13.9
History of abuse to child	40.0	36.1	9.4	11.5	23.4	21.3
Parent(s) experiencing marital problems	43.6	49.5	7.7	6.9	20.5	15.8
Temporary financial problems	55.3	52.3	5.3	7.2	23.7	18.0
Low subsistence level	47.5	50.4	9.8	3.8	21.3	15.9
Chronic neglect	31.1	29.9	13.1	16.4	27.9	23.9
Mother--little love for child	46.2	25.5	15.4	17.0	15.4	29.8
Father--little love for child	30.0	32.2	20.3	8.0	20.3	36.0
Child evidences intellectual problems	31.0	56.5	17.2	4.3	20.7	26.1
Child evidences emotional problems	22.9	47.1	14.2	8.8	31.4	27.9
Child exhibits atypical behaviors	25.7	48.2	17.1	8.9	28.6	28.6
Child evidences physical problems	39.1	57.1	8.7	3.6	17.4	21.4
Parent single living with man	30.8	54.5	15.4	9.1	23.1	27.3
Too many children	68.2	43.5	4.5	6.5	18.2	21.7

TABLE 4-21

Seriousness of Harm and Agency Dispositions

Agency Decisions	Serial Abuse Cases						Isolated Incident Cases						Total Caseload					
	Not Serious		Serious		Unknown		Not Serious		Serious		Unknown		Not Serious		Serious		Unknown	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
In home without services	2	100.0 (4.1)	0	--	0	--	19	82.6 (12.6)	4	17.4 (6.3)	0	--	21	84.0 (10.5)	4	16.0 (4.2)	0	--
In home with services	26	68.4 (53.1)	8	21.1 (25.8)	4	10.5 (80.0)	94	76.4 (62.3)	18	14.6 (28.1)	11	8.9 (78.6)	120	74.5 (60.0)	26	16.1 (27.1)	15	9.3 (83.3)
Emergency removal of child	3	37.5 (6.1)	4	50.0 (12.9)	1	12.5 (20.0)	6	37.5 (4.0)	9	56.3 (14.1)	1	6.3 (7.1)	9	37.5 (4.5)	13	54.2 (13.5)	2	8.3 (11.1)
Emergency removal of other children	2	50.0 (4.1)	2	50.0 (6.5)	0	--	3	42.9 (2.0)	4	57.1 (6.3)	0	--	5	45.5 (2.5)	6	54.5 (6.3)	0	--
Petition for temporary removal of child	9	47.4 (18.4)	10	52.6 (32.3)	0	--	18	52.9 (11.9)	15	44.1 (23.4)	1	2.9 (7.1)	27	50.9 (13.5)	25	47.2 (26.0)	1	1.9 (5.6)
Petition for temporary removal of other children	3	30.0 (6.1)	7	70.0 (22.6)	0	--	8	50.0 (5.3)	7	43.7 (10.9)	1	6.3 (7.1)	11	42.3 (5.5)	15	57.7 (15.6)	0	--
Petition for permanent removal of child	3	100.0 (6.1)	0	--	0	--	0	--	2	100.0 (3.1)	0	--	3	60.0 (1.5)	2	40.0 (2.1)	0	--
Petition for permanent removal of other children	0	--	0	--	0	--	0	--	1	100.0 (1.6)	0	--	0	--	1	100.0 (1.0)	0	--
Informal placement	1	100.0 (2.0)	0	--	0	--	3	42.9 (2.0)	4	57.1 (6.3)	0	--	4	50.0 (2.0)	4	50.0 (4.2)	0	--
Total	49		31		5		151		64		14		200		96		18	

of 21.9 percent of the children age three to less than six and on well under twenty percent of the youngest children (15.5 percent) and those between six and ten (10.8 percent).

The general pattern observed for the filing of petitions by the age of the child appears to persist in the placing of children in foster homes. In the total caseload, there was a tendency for the oldest children on whom petitions were filed to be placed in foster care. Of a total of eight children between six and ten years of age on whom a petition was filed, six or 75.0 percent were placed in foster homes; 66.7 percent of those between ten and fourteen and 75.0 percent of the fourteen and older were so placed. These percentages compare to slightly more than fifty percent of the two youngest age groupings.

When the general pattern was maintained, there were some minimal differences found when we considered the nature of the case. Among the serial abuse cases, children between the age of six and ten and three and six on whom a petition was filed were the most likely to be placed in foster care. All of the children in the former age grouping and over eighty percent of those in the latter were placed in foster care. Sixty percent of the children ten to less than fourteen on whom a petition was filed and 75.0 percent of the fourteen and over were placed in foster homes. The youngest children in the serial abuse caseload were least likely to have petitions filed in their behalf and to go into foster care.

Basically, the pattern of findings was observed for the isolated incident cases. The children in the two oldest age brackets on whom a petition was filed were the most likely to go into foster care. Children age three to less than six were the least likely to be so placed. See Table 4-22 for the complete distribution.

Regarding race, a petition was known to be filed on a higher percent of the black children in the total caseload. According to Table 4-23, 21.4 percent of the white children and 30.6 percent of the black children had petitions filed on their behalf.

There were differences to the above findings when the nature of the case was considered. A petition was filed on a higher percent of the white children (37.1 percent) than the percent of the black children (30.4 percent) in the serial abuse caseload. The reverse was found in the isolated incident caseload; a high of 30.6 percent of the black children were known to have petitions filed on them. This compares to a low of 16.8 percent of the white children.

Children in the serial abuse caseload on whom a petition was filed were more likely to go into foster home placement than were those in the isolated incident caseload–over seventy percent of the former and over fifty percent of the latter.

The placing of children in foster care by race generally followed the pattern observed in the filing of petitions. White children in the serial abuse caseload on whom petitions were filed were more likely to be placed in foster homes (76.9 percent) than were the black children (71.4 percent). Slightly more of the black children in the isolated incident caseload on whom a petition was filed was placed in foster care–57.9 percent to 55.0 percent of the white children.

Noting the data from the standpoint of the number of children in placement as a percent of the children in the total caseload, we found that a higher percent of all white children among the serial abuse cases went into foster care. Slightly more than twenty-five percent of the white and 20.8 percent of the black children were placed in foster home settings. The reverse was found in the isolated incident caseload; only 9.0 percent of all the white children in comparison to 17.2 percent of all the black children were so placed.

In regard to sex and the filing of petitions for removal, there was a slightly higher percent of the males (37.5 percent) than the percent of the females (34.3 percent) in the serial abuse caseload on whom a petition was filed.

The reverse was found in the isolated incident caseload; a petition was filed on 23.3 percent of the females and on 18.8 percent of the males.

Regarding foster home placement, females were more likely in both caseloads to be placed in foster care. Among the serial abuse cases, 83.3 percent of the females and 66.7 percent of the males on whom a petition was filed were placed in foster homes. In the isolated incident caseload, 71.4 percent of the females and only 44.4 percent of the males were placed in foster care. These data are presented in Table 4-24.

TABLE 4-22

Petitions Filed and Foster Home Placement by Age and Nature of the Case

Age	Petition Filed?												Foster Home Placement*					
	Serial Abuse				Isolated Incident				Total Caseload				Serial Abuse		Isolated Incident		Total Caseload	
	Yes		No		Yes		No		Yes		No							
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
< 3	2	22.2	7	77.8	11	15.5	60	84.5	13	16.3	67	83.7	1	9.1 (50.0)	6	8.1 (54.5)	7	8.2 (53.8)
3< 6	6	40.0	9	60.0	7	21.9	25	78.1	13	27.7	34	72.3	5	31.3 (83.3)	2	6.3 (28.6)	7	14.6 (53.8)
6<10	4	26.7	11	73.3	4	10.8	33	89.2	8	15.4	44	84.6	4	25.0 (100.0)	2	5.3 (50.0)	6	11.1 (75.0)
10<14	5	41.7	7	58.3	10	38.5	16	61.5	15	39.5	23	60.5	3	23.1 (60.0)	7	25.9 (70.0)	10	25.0 (66.7)
14<18	4	50.0	4	50.0	8	37.3	16	66.6	12	37.5	20	62.5	3	37.5 (75.0)	6	75.0 (75.0)	9	28.1 (75.0)
Total	21	35.6	38	64.4	40	21.1	150	78.9	61	24.5	188	75.5	16		23		39	

*Percentages within brackets are based on the number of children in placement as a percent of children on whom petitions were filed. Other percentages are based on the number of children in foster home placement as a percent of the total number of children in each age category.

TABLE 4-23

Petitions Filed and Foster Home Placement by Race and Nature of the Case

Race	Petition Filed?												Foster Home Placement*					
	Serial Abuse Yes		Serial Abuse No		Isolated Incident Yes		Isolated Incident No		Total Caseload Yes		Total Caseload No		Serial Abuse		Isolated Incident		Total Caseload	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	13	37.1	22	62.9	20	16.8	99	83.2	33	21.4	121	78.6	10	25.6 (76.9)	11	9.0 (55.0)	21	13.0 (63.6)
Black	7	30.4	16	69.6	19	30.6	43	69.4	26	30.6	59	69.4	5	20.8 (71.4)	11	17.2 (57.9)	16	18.2 (61.5)
Total	20	34.5	38	65.5	39	21.5	142	78.5	59	24.7	180	75.3	15		22		37	

*Percentages within brackets are based on the number of children in placement as a percent of children on whom petitions were filed. Other percentages are based on the number of children in foster home placement as a percent of the total number of children of each race.

TABLE 4-24

Petitions Filed and Foster Home Placement by Sex and Nature of the Case

Sex	Petition Filed?												Foster Home Placement*					
	Serial Abuse				Isolated Incident				Total Caseload				Serial Abuse		Isolated Incident		Total Caseload	
	Yes		No		Yes		No		Yes		No							
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Male	9	37.5	15	62.5	18	18.8	78	81.2	27	22.5	93	77.5	6	23.1 (66.7)	8	8.1 (44.4)	14	11.2 (51.9)
Female	12	34.3	23	65.7	21	23.3	69	76.7	33	26.4	92	73.6	10	26.3 (83.3)	15	16.3 (71.4)	25	19.2 (75.8)
Total	21	35.6	38	64.4	39	21.0	147	79.0	60	24.5	185	75.5	16		23		39	

*Percentages within brackets are based on the number of children in placement as a percent of children on whom petitions were filed. Other percentages are based on the number of children in foster home placement as a percent of the total number of each sex.

Dispositions in Cases Entering the Court*

Table 4-25 reveals that foster home placements accounted for approximately seventy percent of the dispositions rendered in serial abuse cases, and for approximately fifty percent in isolated incident cases entering the court.

In addition to the fact that children among the isolated incident caseload were less likely to be placed in foster care, it appears that the court was more likely to return these children to a paren or some other relative. Of the 21 children in the serial abuse caseload, only one or 4.8 percent was placed with parents and two or 9.5 percent with other relatives. Among isolated incident cases, five or 12.8 percent were placed with a parent and six or 15.4 percent with other relatives.

Previous Placement and Selected Court Dispositions

Of the 21 children in the serial abuse caseload who went before the court, ten of these had a prior placement. It appears that whether or not children had a placement history served as a guide in the court's dispositions. None of the children with a placement history was returned to a parent or placed with other relatives. Three or 27.3 percent of those who had not been previously placed were returned to parents or placed with other relatives. The remaining 72.7 percent were placed in foster care. Eighty percent of the previously placed children were placed in foster homes and 20.0 percent in a voluntary care institution. Succinctly, none of the previously placed children were returned to the family setting.

Seriousness of Harm and Selected Court Dispositions

Seriousness of harm as a factor considered by the court in making its dispositions appeared to have had little relevance. Among the serial abuse cases, the fact of having been previously reported appeared to be a more determining factor in the court's decision-making processes. None of the children who were not seriously harmed was returned to parents and only one or 8.3 percent was placed with other relatives. One each (11.1 percent) of the seriously harmed was placed with parents and with other relatives.

In the isolated incident caseload, one or 5.6 percent of the children who were not seriously harmed was returned to a parent and four or 22.2 percent were placed with another relative. For the seriously harmed, four or 17.4 percent were returned to a parent and five or 21.7 percent with other relatives.

In terms of out-of-the-family placements, including placement with other relatives, seriousness of harmed did not appear to enter in the dispositional judgments. Among the serial abuse cases, 91.6 percent of the children who were not seriously harmed and 77.8 percent of the seriously harmed were placed out-of-the-family environment. The pattern prevailed in the isolated incident caseload; 72.3 percent of the not seriously harmed and 60.8 percent of the seriously harmed were so placed. These findings are presented in Table 4-26.

Family Circumstances and Selected Court Dispositions

Are courts more likely to return children to the home when specific familial circumstances are present or absent? Without controlling for such relevant factors as race and age of child, we attempted elementary analyses of court decisions by family circumstances.

In the total caseload, we found that the highest percentages of the children were returned to one or both parents when parent and/or family related circumstances were present.

The highest percentage of children returned were those who lived in large families; the female parent exhibited sexual, alcohol, and/or drug problems; and the female parent was single and living with a man. This pattern generally held for the isolated incident cases.

For both the isolated incident cases and the total caseload, children were least likely returned to the home when child related circumstances were present. Among the isolated incident cases, the lowest percentage of children were placed with the parent(s) when the child evidenced emotional/psychological problems; the father exhibited sexual, alcohol, and/or drug problems; and the child exhibited behavioral atypicalities. Children in the total caseload were least likely returned when the two above child-related problems and chronic neglect were present.

In relation to the seriousness of harm by the presence of specific familial circumstances, were court decisions

*We are reminded that the court determined whether or not children were returned to the home. The protective service agency was responsible for placement following the court process when the custody was remanded to the agency.

TABLE 4-25

Disposition in Cases Entering the Court by the Nature of the Case

Dispositions	Serial Abuse			Isolated Incident		
	No.	Percent of Children (N=54)*	Percent of Dispositions	No.	Percent of Children (N=63)*	Percent of Dispositions
Placed with both parents	1	4.8	4.5	0	--	--
Placed with mother	0	--	--	3	7.7	6.7
Placed with father	0	--	--	2	5.1	4.4
Placed with other relative	2	9.5	9.1	6	15.4	13.3
Foster home	16	76.2	72.7	23	59.0	51.1
Voluntary care institution	2	9.5	9.1	5	12.8	11.1
State long term care institution	0	--	--	2	5.1	4.4
Continuation	0	--	--	2	5.1	4.4
**Protective supervision	0	--		2	5.1	4.4
General services	1	4.8	4.5	0	--	--
No services	0	--	--	0	--	--

*Percentages add up to an excess of 100 since more than one disposition was made in some cases.

**This is probably a conservative representation of this court ordered disposition inasmuch as the order was not explicitly stated in the court decree in many cases.

TABLE 4-26

Disposition in Cases Entering the Court by Seriousness of Harm

Court Decisions	Total Caseload						Serial Abuse						Isolated Incident					
	Not Serious		Serious		Unknown		Not Serious		Serious		Unknown		Not Serious		Serious		Unknown	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Returned to both parents	0	--	1	100.0 (3.4)	0	--	0	--	1	100.0 (11.1)	0	--	0	--	0	--	0	--
Placed with mother	1	33.3 (3.3)	2	66.7 (6.9)	0	--	0	--	0	--	0	--	1	33.3 (5.6)	2	66.7 (8.7)	0	--
Placed with father	0	--	2	100.0 (6.9)	0	--	0	--	0	--	0	--	0	--	2	100.0 (8.7)	0	--
Placed with other relatives	5	62.5 (16.7)	3	37.5 (10.3)	0	--	1	50.0 (8.3)	1	50.0 (11.1)	0	--	4	44.4 (22.2)	5	55.6 (21.7)	0	--
Foster home	20	51.3 (66.7)	19	48.7 (65.5)	0	--	10	62.5 (81.3)	6	37.5 (66.7)	0	--	10	43.8 (55.6)	13	56.2 (56.5)	0	--
Voluntary care institutions	4	57.1 (13.3)	2	28.6 (6.9)	1	14.3 (100.0)	1	50.0 (8.3)	1	50.0 (11.1)	0	--	3	60.0 (16.7)	1	20.0 (4.3)	1	20.0 (100.0)
Total	30		29		1		12		9		0		18		23		1	

appropriately made? It appears that, with a few exceptions, the courts disposition to return children to the home was not too incongruent with the seriousness of harm by the presence of specific circumstances. In general, courts were least likely to return children to the family when child related problems were present. Where such problems were present, we noted earlier that a high percent of the children were seriously harmed. Conversely, where the parent and/or family related problems such as mother's sexual, alcohol, and/or drug behavior and too many children in the family were present, a lower percent of the children were seriously harmed.

See Table 4-27 for selected circumstances by the percent of children returned to the parent(s). Also see Table 2-38 for seriousness of harm and family circumstnaces.

Services Rendered

No services, beyond those implied in the investigatory process, were rendered to 6.3 percent of the children and 14.1 percent of the parents in the serial abuse caseload, and to 17.9 percent of the children and 24.1 percent of the parents in the isolated incident caseload.

Specific services rendered to children and their families are presented in Table 4-28. Observing the percentage distribution of the services, one notes that some services were utilized to a limited degree; some were rendered to a similar percent in both types of cases; and some were more likely rendered in one type than in the other. The following discussion is based on this observation.

Limited Services Rendered.–The child's rights to legal representation during abuse and neglect judicial proceedings has become a major concern in recent years. Such services, however, were virtually absent to the children who entered Savannah's PSU. We noted in an earlier section that in approximately one-third of the serial abuse cases and in twenty percent of the isolated incident cases, a petition for removal was filed and the case was heard by the court. Yet, referral for legal counsel was a service rendered for only 1.6 percent of the serial abuse caseload and for 3.1 percent of the isolated incident caseload. On the other hand, legal services were availed to 7.8 percent of the parents among the serial abuse cases and to only 1.0 percent among the isolated incident cases.

Social isolation is one of the major characteristics attributed to abusing and/or neglecting parents. Given this fact, it would seem that one of the major services caseworkers can offer parents of abused and neglected children is the opportunity for cultural and recreational outlets. There was no evidence, however, that any parents among either type of cases were rendered such services.

Some of the services which could be considered basic to the self-improvement of parents were not rendered in many cases. Tutorial or teacher aide services were rendered to 1.6 percent and 2.6 percent of the parents among the serial abuse and the isolated incident cases, respectively. Instruction in food preparation was provided in 4.7 percent of the serial abuse cases and in only 0.5 percent of the isolated incident cases.

While casework counseling was provided to many parents and focusing on a variety of issues, counseling with the child was a service rendered in a small percent of the cases–6.3 percent of the children in the serial abuse caseload and 4.1 percent of the children in the isolated incident caseload. Given the fact that approximately one-fourth of the children were age ten and older, it would appear that counseling with the child would be a most likely service provided.

The services of homemakers were provided in a relatively small percent of the cases. A surprising observation, however, was the fact that such services were as likely rendered to families in the isolated incident caseload (8.2 percent) as they were to families in the serial abuse caseload (7.8 percent).

Services Rendered in Similar Percent of Cases in Both Caseloads.–A high percent of children among both types of cases were referred for mental services–25.0 percent of those among the serial abuse cases and 22.1 percent of those among the isolated incident cases.

Casework counseling around most problematic areas was similarly rendered to parents among both types of cases. Counseling regarding disciplinary matters was provided to 15.6 percent of the parents in the serial abuse caseload and to 16.9 percent of those in the isolated incident caseload. Counseling on marital problems was provided to 12.5 percent and 16.4 percent of the parents among the serial abuse and the isolated incident cases, respectively. Parent-child interaction as the focus of counseling was a service rendered to approximately twelve percent of the parents among both types of cases. Family planning counseling was rendered to 14.1 percent of the parents in the serial abuse caseload and to 10.3 percent of

TABLE 4-27

Court's Return of Children to the Home by Circumstances Present and the Nature of the Case

Court's Return of Children to the Home by Circumstances Present and the Nature of the Case

Circumstances*	No. of Cases in which Circumstances was Present	Percent of Children Returned when Circumstance was Present
Isolated Incident		
Child evidences physical problems	7	42.9
Parent single living with man	3	33.3
Too many children in the family	10	30.0
Child evidences emotional/ psychological problems	20	5.0
Father's sexual, alcohol, drug problems	16	6.3
Child exhibits behavioral atypicalities	16	6.3
Total Caseload		
Too many children in the family	13	22.1
Mother's sexual, alcohol, drug problems	35	17.1
Parent single living with man	6	16.7
Child evidences emotional/ psychological problems	31	3.2
Child exhibits behavioral atypicalities	28	3.6
Chronic neglect	33	6.1

*Data on circumstances and the return of children in the serial abuse caseload have been omitted due to the fact that very few children in the caseload were returned to one or both of the parents.

TABLE 4-28

Services Rendered by Nature of the Case

Services Rendered	Serial Abuse		Isolated Incident	
	N	%	N	%
No services to child	4	6.3	35	17.9
No services to parent(s)	9	14.1	47	24.1
Referral mental services--child	16	25.0	43	22.1
Referral physical services--child	18	28.1	39	20.0
Referral legal services--child	1	1.6	6	3.1
Referral mental services--parent(s)	22	34.9	38	19.6
Referral physical services--parent(s)	12	18.8	22	11.3
Referral legal services--parent(s)	5	7.8	2	1.0
Collection/repair material goods	4	6.3	4	2.1
Transportation professional services	9	14.1	18	9.2
Cultural-recreational opportunities--child	9	14.1	9	4.6
Cultural-recreational opportunities--parent(s)	0	--	0	--
Tutoring/teacher aide/educational opportunities	1	1.6	5	2.6
Instruction in food preparation	3	4.7	1	0.5
Transportation personal needs	6	9.4	10	5.1
Child care or day care	15	23.4	28	14.4
Supervision of children	1	1.6	3	1.5
Counseling-child development needs, problems	33	51.6	79	40.5
Counseling-child discipline	10	15.6	33	16.9
Counseling-marital problems	8	12.5	32	16.4
Counseling-budgeting	9	14.1	19	9.7
Counseling-parent/child interaction	8	12.5	25	12.8
Counseling-family planning	9	14.1	20	10.3
Counseling-home management	10	15.6	26	13.3
Counseling-parent/parent/child interaction	3	4.7	7	3.6
Counseling-parent development	4	6.3	10	5.1
Counseling-parent view of the world	3	4.7	11	5.6
Counseling-parent role	2	3.1	5	2.6
Counseling with child	4	6.3	8	4.1
Counseling-no special focus determined	7	10.9	32	16.4
Homemaker services	5	7.8	16	8.2
Public financial assistance	27	42.2	80	41.0
Food preparation	0	--	1	0.5
General cleaning	1	1.6	4	2.1
Home visitation-protective supervision	54	84.4	148	75.9

Percentages are based on the total number of cases in the caseloads.

those in the isolated incident cases. Counseling around home management problems was provided to 15.6 percent and 13.3 percent of the parents in the serial abuse and the isolated incident cases, respectively.

Public assistance was provided in slightly more than forty percent of both caseloads

Services More Likely in a Particular Type of Caseload.– PSU personnel availed themselves of the community's professional services for the parents of abused and/or neglected children. Referral for mental services was provided for approximately one-third of the parents among the serial abuse cases; this compares to slightly less than one-fifth of the parents among the isolated incident cases. Referral of parents for physical services was made in 18.8 percent of the serial abuse cases and in 11.3 percent of the isolated incident cases. We noted earlier that while referral of parents for legal services was a limited service, the service was more likely provided in the serial abuse caseload.

Cultural and/or recreational opportunities were provided for 14.1 percent of the children in the serial abuse caseload and for only 4.6 percent of those in the isolated incident caseload.

Child or day care services were more likely provided to families among the serial abuse cases (23.4 percent) than to those among the isolated incident cases (14.4 percent). Similarly, counseling on the development, needs, and problems of children was provided to a higher percent of the parents among the serial abuse cases--51.6 percent in comparison to 40.5 percent among the isolated incident cases.

Caseworkers visited homes as an element of protective supervision in 84.4 percent of the serial abuse cases and in 75.9 percent of the isolated incident cases.

While approximately seventy percent of the families in the serial abuse caseload as compared to slightly less than fifty percent in the isolated incident caseload were determined to exist at a low subsistence and general living level, approximately fifty percent of the parents in both caseloads were experiencing temporary financial hardships. Casework counseling, however, did not appear to address the families' needs. Counseling centered on budgetary matters was a service rendered in 14.1 percent of the serial abuse cases and in less than ten percent (9.7) of the isolated incident cases.

Comparative Summary of Systems Output

1. Characteristics of the Children and Agency Dispositions

Case Dispositions by the Nature of the Case

In both systems' caseload, the two most frequent case dispositions were to allow the child to remain in the home with services and to petition for the temporary removal of the child. Emergency removal was effected in slightly less than twenty percent of CES serial abuse cases and slightly over twenty percent of the isolated incident cases. This compared to approximately twelve percent of the serial abuse and less than ten percent of the isolated incident cases in the PSU caseload.

In the CES caseload, children among serial abuse cases were more likely than those among isolated incident cases to be allowed to remain in the home with services. Petition for temporary removal of the child and emergency removal were slightly more frequent dispositions for children among isolated incident cases. The opposite was observed in the PSU caseload where a higher percentage of the more severe dispositions was made in serial abuse cases.

Age and Selected Dispositions

Among CES serial abuse cases, children less than age three and those fourteen and above were the least likely allowed to remain in the home with services, and the most likely removed on an emergency basis and to have petitions for temporary removal filed on their behalf. In the PSU serial abuse caseload, the two oldest age groups of children--ten to less than fourteen and fourteen and older--were similarly affected by agency dispositions.

The pattern observed in the serial abuse cases persisted for the PSU isolated incident cases. However, among isolated incident cases in the CES caseload, children age ten to less than fourteen were the least likely to remain in the home with services and the most likely to have a petition for temporary removal filed in their behalf.

Sex and Selected Dispositions

Among both systems' serial abuse cases, females were more likely to remain in the home with services; males were more likely to have a petition filed on their behalf.

A higher percent of the females among CES serial abuse cases were removed on an emergency basis. The opposite was observed in the PSU serial abuse caseload.

The pattern for CES isolated incident cases was the same as that found in the serial abuse caseload. Among PSU isolated incident cases, the pattern was just the reverse of that found in the serial abuse caseload.

Race and Selected Dispositions

Among CES serial abuse cases, a higher percent of the more "lenient" dispositions were rendered in cases involving black children, i.e., allowed to remain in the home with services, less likely removed on an emergency basis and to have a petition filed on their behalf. The opposite was observed among the isolated incident cases.

In the PSU serial abuse and isolated incident caseloads, a higher percent of the white children were allowed to remain in the home with services, while a higher percent of the black children were removed on an emergency basis. A petition for temporary removal was filed on a slightly higher percent of the white children in the serial abuse caseload and on a higher percent of the black children in the isolated incident caseload.

2. Previous Placement and Dispositions

In noting agency's dispositions in serial abuse cases, a previous placement appeared to have been a factor considered by PSU caseworkers in the decision-making process. Children with a placement history were less likely allowed to remain in the home with services and more likely to be removed on an emergency basis and to have a petition filed on their behalf.

On the other hand, there was no difference between the percent of the children with and without a placement history in the CES caseload who were allowed to remain in the home with services. The children who were not previously in placement were approximately three times as likely to be removed on an emergency basis. However, a petition for temporary removal was filed on a higher percent of the children with a placement history.

3. Seriousness of Harm and Dispositions

Seriousness of harm appeared to serve as a guide in the decision-making process in the case dispositions made by PSU caseworkers. In the serial abuse caseload, twice as many of the children (over fifty percent) who were not seriously harmed than those who were seriously harmed remained in the home with services. Over twelve percent of the seriously harmed, in comparison to approximately six percent of those who were not seriously harmed, were removed on an emergency basis. A petition for temporary removal was filed on the behalf of approximately one-third of the children who were seriously harmed and on less than twenty percent of those who were not seriously harmed. While the percentages differed, the above pattern was observed in the isolated incident caseload. In general, a higher percent of severe dispositions was made in serial abuse cases.

Among CES serial abuse cases, there were minimal differences made between dispositions in cases involving serious and non-serious harm. Just over thirty percent of the children in both categories of severity were allowed to remain in the home with services; approximately fifteen percent were removed on an emergency basis; a petition for removal was filed in approximately one-fourth of the non-serious cases and slightly less than one-third of the serious cases.

While there were minimal differences in the dispositions made in non-serious cases in both the CES serial abuse and the isolated incident cases, isolated incident cases involving serious harm were less likely returned home, more likely removed on an emergency basis and to have a petition filed on the behalf of the children.

4. Petitions Filed and Foster Home Placement

A petition for removal was filed in slightly more than fifty percent of CES serial abuse and isolated incident cases. This compares to a petition being filed in slightly more than one-third of PSU serial abuse cases and just over twenty percent of the isolated incident cases.

Foster home placement represented 43.3 percent of the dispositions (Nashville, CES) affecting 48.1 percent of the children in the serial abuse caseload, and 32.5 percent of the dispositions affecting 39.7 percent of the children in the isolated incident caseload.

In the Savannah PSU caseload, foster home placement represented 72 1 percent of the dispositions affecting 76.2 percent of the children in the serial abuse caseload,

and 51.1 percent of the dispositions affecting 59.0 percent of the children in the isolated incident caseload.

Thus, while children in the CES caseload were more likely to have petitions filed on their behalf, they were considerably less likely than those in the PSU caseload to be placed in foster care.

Age and Petitions Filed

Among CES serial abuse cases, children less than three years old and those fourteen and older were the most likely to have a petition filed on their behalf. Among the isolated incident cases, the two oldest groups of children–ten to less than fourteen and fourteen and older–were the most likely affected; over ninety percent of the former and well over fifty percent of the latter.

In the PSU serial abuse and isolated incident caseloads, a petition was filed most often on children in the two oldest age groups. Those least likely to be affected by a petition were less than three among the serial abuse cases and those between six and ten among the isolated incident cases.

Age and Foster Home Placement

A higher percent of children between the age of six and ten in CES serial abuse and isolated incident cases were placed in foster care. The two oldest groups of children among both types of cases were the least likely placed in foster home settings. Among CES serial abuse cases, a petition was filed on just under fifty percent of the children age ten to less than fourteen and on 60.0 percent of those fourteen and above, with 37.5 percent of the former and only 22.2 percent of the latter being placed in foster care. Similar observations were made in isolated incident cases. A high of 92.9 percent of the children, age ten to less than fourteen, had a petition filed on their behalf; only 23.1 percent were placed in foster care. A petition was filed on 56.2 percent of the fourteen and older children with 22.2 percent being placed in a foster home.

Among PSU serial abuse cases, all of the children age six to less than ten, on whom a petition was filed, were placed in foster care. Over eighty percent of the three to less than six and three-fourths of the fourteen and older were so placed. Among the isolated incident cases, seventy percent of the ten to less than fourteen and three-fourths of the fourteen and older were placed in foster homes. Children between the age of three and six (28.6 percent) were the least likely to be so placed.

Race and Petitions Filed

White children in CES serial abuse caseload (61.9 percent) were more likely than black children (35.7 percent) to have a petition filed on their behalf. On the other hand, black children among the isolated incident cases (66.7 percent) were more likely than white children (49.2 percent) to be affected by a petition.

The above pattern was also observed in the PSU cases. In the serial abuse caseload, a petition was filed on 37.1 percent of the white children and on 30.4 percent of the black. Among the isolated cases, a petition was filed on 16.8 percent of the white children and on 30.6 percent of the black children.

Race and Foster Home Placement

Slightly more of the black children in the CES serial abuse and isolated incident caseloads, on whom a petition was filed, were placed in foster care. Fifty percent of the black children and 47.7 percent of the white among the serial abuse cases were placed in foster homes. Among the isolated incident cases, 43.8 percent of the black children and 36.4 percent of the white were so placed.

A higher percent (76.9) of the white children than the percent of black children (71.4) in the PSU serial abuse caseload, on whom a petition was filed, was placed in foster care. The opposite was observed in the isolated incident caseload--55.0 percent white and 57.9 percent black were placed in foster homes.

Sex and Petitions Filed

A slightly higher percent of the females (53.1) in the CES serial abuse caseload than the percent of males (52.8) had a petition filed on them. The reverse was found among the isolated incident cases where 55.4 percent males and 50.0 percent females were affected by a petition.

In the PSU serial abuse caseload, a petition was filed on 37.5 percent of the males and 34.3 percent of the

females. Among the isolated incident cases, a petition was filed on a higher percent of the females–23.3 to 18.8 percent of the males.

Sex and Foster Home Placement

While a petition was filed on a slightly higher percent of the females in the CES serial abuse caseload, a higher percent of the males on whom a petition was filed (53.6) were placed in foster care. This compares to only 42.3 percent of the females. The opposite was observed in the isolated incident caseload; only 32.3 percent of the males as compared to 46.9 percent of the females were so placed.

A considerably higher percent of females in both types of the PSU cases were placed in foster care. Among the serial abuse cases, 83.3 percent females and 66.7 percent males on whom petitions were filed were placed in foster homes. In the isolated incident caseload, 71.4 percent females and 44.4 percent males were so placed.

5. Dispositions in Cases Entering the Court

Court Dispositions by the Nature of the Case

We noted earlier that foster care placement represented slightly more than forty percent of the dispositions in CES serial abuse caseload and just under one-third of the dispositions in the isolated incident caseload. By comparison, foster care placement represented more than seventy percent of the dispositions in PSU serial abuse caseload and slightly more than fifty percent in the isolated incident caseload.

Children in the CES caseload were more likely returned to one or both parents which represented 15.0 percent of the court's dispositions in serial abuse cases and affecting 16.7 percent of the children. By comparison, only 4.8 percent of the children in the PSU serial abuse caseload were returned to one or both parents. This represented 4.5 percent of the court's dispositions.

Among isolated incident cases, 23.7 percent of the children (19.5 percent of court's dispositions) in the CES caseload and 12.8 percent of those (11.1 percent of court's dispositions) in the PSU were returned to one or both parents.

Previous Placement and Selected Court Dispositions

In both systems, it appeared that whether or not children had a placement history served as a guide in the court's dispositions. In neither system's serial abuse caseload were children with a placement history returned to one or both of the parents. This compares to over twenty percent so placed who had not been previously placed.

Children with a placement history were more likely placed with other relatives and in a voluntary care institution than were those who had not been in placement.

Seriousness of Harm and Selected Court Dispositions

In the CES caseload, there was little difference between the percent of children who were and were not seriously harmed in both types of cases who were returned to one or both parents. Children in the isolated incident cases were more likely returned to their parents.

Seriousness of harm as a factor considered by the court in making its dispositions appeared to have little relevance among PSU cases. The fact of having been previously reported appeared to be a more determining factor in the decision-making process; only one of 21 children in the serial abuse caseload was placed with a parent. A higher percent of the seriously harmed, among isolated incident cases, were returned to one or both parents.

Family Circumstances and Selected Court Dispositions

The highest percent of cases in the CES isolated incident[illegible] in which children were returned to a parent(s), were those in which the child evidenced intellectual problems or exhibited atypical behaviors, and parents were experiencing marital problems. Children in the isolated incident caseload were least likely returned to a parent when chronic neglect, low living level, and father evidenced little love for the child were circumstances.

Among CES serial abuse cases, the highest percent of cases in which children were returned to a parent(s) were those in which the male parent was promiscuous and/or had alcohol and/or drug problems; there was a

history of abuse, and child evidenced intellectual problems. They were least likely returned when parents evidenced intellectual problems. They were least likely returned when parents evidenced physical problems, neglect was chronic, and the female parent was promiscuous and/or had alcohol and/or drug problems.

In the PSU isolated incident caseload, the highest percent of cases in which children were returned to a parent were those in which the child evidenced physical problems, the female parent was single but living with a man, and there were too many children in the family. Children were least likely returned when they evidenced emotional problems, the male parent was promiscuous and/or had alcohol and/or drug problems, and the child exhibited atypical behaviors.

6. Actual Services Rendered to Children and Their Families

We were unable to determine a family-oriented design to the pattern of services based on the circumstances present.* A sizable percentage of families in both systems' caseload received some basic services; namely, counseling on the needs and problems of children; protective supervision, public financial assistance, and referral for mental and health services. Some services were notably absent--referral for legal services, cultural/recreational opportunities for child and/or parents, casework counseling with the child, "how-to-skills" oriented services, and counseling centered on family interactions.

Several points are noted which indicate the absence of a family oriented design to service delivery:

a. We noted that marital problems plagued approximately forty percent of the families in both systems' caseload. Evidence indicated that marital counseling was a service present in around fifteen percent of the cases.

b. Approximately one-fourth of the children were age ten and above; however, neither system provided counseling to the child in as much as ten percent of the cases.

c. In both systems' caseload, neglect due to parental inadequacies was one of the most frequent observed types of abuse. Many of these families were characterized by too many children, chronic neglect, and family hardships. Yet social work counseling around such basic areas as home management, family planning, and budgeting was in small supply.

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*We recognize that many intangible services such as problem-related counseling could have been rendered and not documented in the case workers' narrative accounts of case handling, such services therefore would be present for the family but absent for research purposes. Thus, our observation would be a disservice to the service provider. However, if we are indeed mindful of such factors as the need for accountability, the need to measure progress in a specific problem area, and the high turnover rate of workers assigned to cases, it appears essential that such intangible services, if not now documented, should be.

Chapter 5

EFFECTIVENESS OF SYSTEMS' INTERVENTION

Introduction

Evaluation research involves the collection of data for the explicit purpose of making some determination regarding the outcome or effectiveness of a program or a system's functioning. *While program evaluation is a valuable decision-making tool, it can be considered a dangerous thing.* The fate of a program is often dependent upon its own evaluation. In view of negative evaluation, the program might be junked. By the same token, positive evaluation might lead to a proliferation of similar programs and/or additional funding for program operations. Needless to say that many good programs have been junked and many bad programs have been given new life through the powers inherent in evaluations.

Part of the problem leading to the above situation, undoubtedly lies in the misuse of evaluations. Consumers of evaluation research often disregard the interconnectedness between the objectives of the program, the objectives of the research, and the conduct of the research. Succinctly, consumers often tag on to a particular finding, without an understanding of the total enterprise. Beyond this, researchers themselves often go beyond the limits of their findings in assessing the outcome or impact of the programs they evaluate.

To minimize the misuse of this evaluation research, we have emphasized at various points the limitations in the study and major considerations of which the consumers *must* be aware in order to make an objective determination of the values of the research findings for their own purposes. Beyond this, while evaluation research is in the end judgmental, the researcher has been ever conscious about the problem and has made every attempt to make interpretations and recommendations within the confines of the findings.

Individual Case Analysis: The Method

The total caseload for this study was analyzed by decks of case data from each protective service system. Deck 1 throughout this report refers to serial abuse cases. In such cases there is a deck 3--a prior incident--and in some cases a deck 4, an even earlier incident. Deck 2 refers to cases on which only one incident was investigated by the system. Succinctly, decks 1 and 2 represent a system's total caseload, with decks 3 and 4 representing prior incidents of Deck 1.

It is of importance at this point to restate the procedures and definitions used in selecting cases for the study. By so doing, the reader may better understand the limitations as well as the values in the subsequent findings based on small numbers of cases.

The selection of cases was based on the nature of the complaint (definition) and a determination of one child per family.

Cases were considered for this study if they involved:

1. abandonment,
2. physical harm which was not accidental or otherwise ruled out by the worker/agency,
3. neglect either from deliberate acts designed to result in neglect, e.g., withholding of food, placing children out-of-doors in inclimate weather as a form of punishment, etc. or acts designed for an unrelated purpose which result in neglect, e.g., leave child unattended while out on "the town,"
4. neglect resulting primarily from parental inadequacies in child rearing practices, home management, etc.,
5. sexual abuse, and
6. emotional abuse which was determined on a case-by-case basis from the narrative case account.

In terms of case selection, we excluded all cases which resulted from one or more of the following:

1. accidental injuries,
2. neglect due to family illness/hospitalization,

3. family crisis which could have negative consequences for familial stability, e.g., death, unemployment, and

4. personal report involving voluntary placement of children in the absence of abuse and neglect.

The logic for the exclusion of the above types of cases is two-fold:

1. such cases were not handled by Savannah's PSU system, and

2. while the welfare of children and their families are at stake in such cases, the decisions made and the treatment required are basically different from that involved in cases generally defined as abuse and neglect.

As indicated earlier, one child per family was selected for inclusion in the study. If there were more than one child in the family, a schedule was completed for the child representing repeated abuse. If more than one child represented repeated abuse, the child reported most often was used. If none of the children represented repeats, a schedule was completed on the youngest child. If all of the children had been reported more than once but for the same number of times, a schedule was completed on the oldest child who was yet under the care of the parent or guardian.

For the individual case analyses, which involved a time-series look at case data in terms of reported incidents, only the serial abuse cases were utilized. For the detailed case analyses on effectiveness of intervention, which necessarily involve analysis of case "happenings" within the study time frame, the serial abuse (deck 1) caseload in both systems was decreased significantly due to the deletion of all cases in which all incidents prior to the most current were reported prior to August, 1971.*

Thus, while the numbers of cases for the individual case analyses are small, they represent the total population of abuse and neglect cases–by our operational definitions and procedures for case selection–which were first known to and handled by each system after August, 1971.

Had we taken each child in each family the number of cases for analysis would have increased significantly; however, there is little indication that the findings would have been drastically different. Some data suggest that often one child may be selected in a family for maltreatment. We have allowed for this possibility in our case selection procedures. Therefore, we would suggest that the efficacy of the findings based on our small samples is not violated.

The caseload for both systems was analyzed by the type of serial abuse case; namely, two-report or incident cases–the current and one prior incident, and three-report or incident cases–the current and two prior incidents.*

In order to identify each case on the computer printout, relevant identifying and background variables of data pertinent to the evaluation criteria were computer processed. From the printout, the computations and analyses on effectiveness were a manual operation such that our findings are specific to individual children rather than being aggregations of the data. For example, instead of making statements on effectiveness by indicating that fewer children in the caseload were seriously harmed in the current incident than in the prior incident, we are able to say that fewer of the same children were so harmed and/or that a given number and percent of the same children were seriously harmed in both or all three incidents.

Considerations: Evaluation Criteria

Considerations to be noted below relate to the evaluation criteria and are basic to the interpretations and utilization of the findings.

Recidivism as a Criterion.–In an ensuing section of this chapter it will be noted that the overall recidivism rate in the CES system was significantly higher than that in the Savannah's PSU system. It is our intent herein to point out that these differences undoubtedly can be explained, in part, by the difference in level of community awareness and child

*The CES system began operations in August, 1971. Thus for both systems we have taken this date as the time frame for evaluating effectiveness. In other words, the effectiveness of a system should not be evaluated on the basis of intervention which occurred prior to its own inception.

*A small percent of the cases in both systems had more than two prior reports. However, due to the small numbers we did not computer process them.

abuse and neglect activities, and by the differences in the systems' case handling procedures.[1]

Length of Time Between Incidents as a Criterion.–In reference to the period–one year–cases were considered which were reported within the same year or within a year's time. This avenue was taken due to the absence of the month of the report in some cases. This was particularly true of Savannah's data. Beyond this, with the exception of the year of the incident, the time element on a large number of records in Savannah's case data was not present.

Of importance in the interpretation and utilization of findings in terms of this criterion is an understanding of the two systems' procedures for and the comprehensiveness of coverage in investigating complaints.[2] Beyond the limitations previously attributed to the time factor as a criterion, one must be cognizant of the fact that reportedly all complaints directed to the CES intake were investigated. On the other hand, this was not the case in Savannah's intake unit. Thus, in Savannah's caseload, two incident/report and three incident/report refer to the number of times cases were investigated rather than reported.

Seriousness of Subsequent Harm as a Criterion.–The major limitation to the utilization of this variable was the fact that only two levels of severity were considered; namely, not serious and serious. Beyond this, the N's on which the findings are based are considerably smaller than that utilized for the other criteria. This is true because of our considering the extent of harm to be unknown in any case in which we questioned the status of the child's condition. While seriousness can be considered a rather subjective criterion, the findings represent a most conservative picture in that we evaluated harm in the above manner.

Rehabilitation of Perpetrator as a Criterion.–Inferences about effectiveness are made both from the involvement of the perpetrators and from the types of harm sustained by the children.

In determining whether or not the type of abuse remained the same over time, we only included cases having the identical number and type(s) of abuse for all incidents. This represents a conservative number in both systems since a large percent of the cases involved the same type abuse with one or the other incident involving one or more additional types.

Agency Disposition as a Criterion.–Since subjective judgments are involved in the determination of the severity of agency dispositions–agency actions, consequences to the child, effect on the family, etc.–the following were the guides which were applied in classifying severity of disposition:

1. Emergency removal and petition for temporary removal were considered approximately equally severe, *except when one or the other involved the harmed child and other children.*

2. A combination, e.g., emergency removal and petition for temporary removal, was considered more severe than either as a single consequence.

3. Both remain in home with and without services were considered non-severe agency dispositions. However, when they appeared in the same individual case, remain-in-the-home with services was considered more severe than remain-in-the-home without services.

4. Informal placement with relatives was considered a non-severe disposition. However, informal placement for a former incident followed by remain-in-the-home with or without services was considered a case in which the current disposition was less severe than the earlier. By the same logic, informal placement in the current incident, preceded by emergency removal and/or petition for removal, was considered a less severe disposition.*

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[1] For differences in level of community awareness, see Johnson, *Two Community Protective Service Systems*, pp. 38-40. In the same reference, see pp. 42-43 for differences in case handling procedures.

[2] Ibid., pp. 41-42.

*We recognize that the term "*severity* of disposition" carries a ring of punishment about it. This is not the writer's intent, nor that of most workers. Nevertheless, for want of a better term to relate the direction dispositions took over time, the "severity" concept has been employed.

Effectiveness of Intervention in the CES System

Recidivism as a Criterion

Recidivism was noted on two levels; namely, in the total caseload and in the caseload for which individual case analyses were performed to determine effectiveness of intervention.

Of a total of 232 cases in the total caseload, 104 or 44.8 percent represented cases on which at least one report prior to the most current had been made–serial abuse cases.

Thus, 128 or 55.2 percent represented isolated incident cases. In short, this means that just under one-half of all the children in the sample re-entered the system after the initial report.

Of the serial abuse cases (N=104), 66 or 63.5 percent were cases on which only one prior report was made; 38 or 36.5 percent represented cases on which two or more incidents, excluding the most current, had been investigated.

For detailed analyses of effectiveness, which necessarily involve analysis of case "happenings" within the time frame of the program being evaluated, the caseload was decreased significantly due to the large number of cases in which reports prior to the most current within the series of incidents occurred prior to August, 1971–the initiation of CES.

Of the 104 cases in the serial abuse caseload, only 66, which served as the population for further analysis of effectiveness, fell within the study period. Of these, 42 or 63.6 percent involved only one prior report; 24 or 36.4 percent involved two or more prior reports.

Thus, it appears that there was a high recidivism rate for both levels in the CES system.* Of the children who entered the protective service system since the inception of CES through the first quarter of 1974, slightly more than one-third of them were involved in three or more incidents during that period.

*There are many factors which undoubtedly contributed to this occurrence, among which were probably the level of awareness due in part to the existence of the program, 24-hour intake, and coordinated efforts between collateral systems.

Length of Time Between Incidents as a Criterion

Forty-two or 63.6 percent of the 66 cases reported within the study period were reported twice within the same year or within a year's time. Of the 66 cases, 20 or 30.3 percent were reported twice within six months.

Two-Report Cases

Noting the length of time between incidents for cases on which only one prior report had been made (N=42), we found that 27 or 64.3 percent were reported twice within a year's time. In 12 or 28.6 percent of the cases, both reported incidents occurred in less than six months.

It appears from the above data that not only did children return to the CES system at a high rate, but their return in a high percent of the cases was often in a very short period of time. Noting this occurrence, we analyzed the criterion as it applied only to cases first reported after December 31, 1972.* Thirty-six cases were in this time period; 22 or 61.1 percent represented cases on which only one prior report was made and 14 or 38.9 percent were cases on which two or more prior reports were investigated.

Of the 22 cases with only one prior reported incident, 19 or 86.4 percent represented cases in which there was less than one year between the two reports. In 8 or 36.4 percent, six months or less was the length of time between the reports.

By noting only cases first reported after December 31, 1972, it appears that, by the length of time between incidents as a criterion, intervention was even less effective than was noted for the total caseload in the study period. Over eighty percent of the same children on whom two reports were made entered the CES system a second time within the same year or within a year's time.

Characteristics of Children in Two-Report Cases Who Re-entered the System Within a Year's Time.–In the two-incident/report cases, 6 or 22.2 percent of the children were

*To make inferences about effectiveness based on all cases responded to from the beginning of the CES project might present a biased picture. By noting time as a criterion from cases later in the study period, we would assume that program operations and procedures for case handling would be "ironed" out. In addition, gains in expertise would be expected over time.

black; 20 or 74.1 percent were white; and the race of 1 or 3.7 percent was unknown.

A relatively large percent of these children tended to be young. Nineteen or 70.3 percent were less than six years of age, with 44.4 percent of these being one but less than three. Only 2 or 7.4 percent were between the age of six and ten. Six or 22.2 percent were age ten and above, with 4 or 14.8 percent of these being between fourteen and sixteen.

In terms of types of abuse these children suffered, 14 or 51.9 percent of the 27 cases involved physical abuse in one or both incidents. In 8 or 29.6 percent of the cases, the child suffered from physical abuse in both incidents. One child was sexually abused twice within a period of one year.

How did these children differ from the children who did not re-enter the system within a year's time? Five or 33.3 percent of the 15 children involved in two incidents who did not re-enter the system within a year's time, were black; 10 or 66.7 percent were white. Age-wise, these children tended to be older. Nine or 60.0 percent were less than age six; 3 or 20.0 percent were between the age of six and ten; and 3 or 20.0 percent were ten and older.

Three-Report Cases

There were 24 cases on which two or more prior reports were made. In 16 or 66.7 percent of these cases, less than one year elapsed between each incident. In 8 or 33.3 percent less than a period of six months expired between incidents. In nine or 37.5 percent of the 24 cases, all three reports were investigated within a period of less than one year. All three reports were made within six months in 3 or 12.5 percent of the cases.

In the three-report cases (N=14) first reported after December 31, 1972, there was one year or less between each incident in 12 or 85.7 percent of the cases. Seven or 50.0 percent represented cases in which there were six months or less between each incident. In 2 or 14.3 percent of the cases, all three incidents occurred within a period of six months.

Characteristics of Children in Three-Report Cases Who Re-entered the System Within a Year's Time.–Among the three-report cases for which there was a year or less between incidents, 14 or 87.5 percent were white and 2 or 12.5 percent were black. Regarding age, only 9 or 56.3 percent were less than six, and 1 or 6.3 percent were ten years or above. The age of one child was unknown.

Of the children who were involved in three incidents with more than a year between the incidents, 3 or 37.5 percent were black and 5 or 62.5 percent were white. These children tended to be older than those who re-entered the system within a year's time. Only 3 or 37.5 percent were less than six years of age; 1 or 12.5 percent was age six but less than ten; and 4 or 50.0 percent were ten years and above.

Seriousness of Harm as a Criterion

Two-Report Cases

Seriousness of harm for both incidents, in cases on which there were two reports, was known in thirty of the 42 cases. In 15 or 50.0 percent of these cases, neither reported incident involved serious harm to the child. In one case (3.3 percent) the child was more seriously harmed in the earlier of the two incidents. Eight or 26.7 percent of the children were more seriously harmed in the current of the two incidents; and 6 or 20.0 percent were seriously harmed in both incidents.

If we can assume that not being seriously harmed in either incident and being less seriously harmed in the current incident are indications of effectiveness of intervention, we can assume that ineffectiveness can be inferred from situations in which the current of two incidents involved more serious harm to the child and from situations in which serious harm was incurred in both reported incidents. If these are logical assumptions, we note that for 53.3 percent of the children intervention was effective; for 46.7 percent intervention was ineffective.

We noted seriousness of harm suffered by the children who re-entered the system in less than a period of one year. Of the thirty two-report cases for which seriousness of harm was known in each incident, 5 or 16.7 percent were reported twice within the same year or within a year's time and were more seriously harmed in the current of the two reported incidents. Four or 13.3 percent of the children were reported twice within the year's time period and were seriously harmed in both incidents. Thus, for 30.0 percent of the children on whom two reported incidents occurred within a period of one year, intervention was ineffective as inferred from seriousness of subsequent harm as a criterion. More importantly, in 2 or 6.7 percent of the cases both incidents were reported within a six month period with the harm being more serious in the current incident. In 3 or 10.0 percent of the cases both incidents were reported twice in a six month period with harm being serious in both incidents. Thus, we

find that for 5 or 16.7 percent of the children who entered the system twice in a six month period, intervention was not effective.

As indicated earlier, we felt a need to apply the evaluation criteria to case happenings at a later time in the CES project, i.e., as of December 31, 1972. There were fifteen two-report cases in this time period for which seriousness of harm was known for both incidents. In eight or 53.3 percent of these cases, neither reported incident involved serious harm to the child, there were no cases in which harm was more serious in the earlier of the two incidents. Three or 20.0 percent of these children were more seriously harmed in the more current of the two incidents, and 4 or 26.7 percent were seriously harmed in both reported incidents. Again, we find that for 53.3 percent of the children intervention was effective; and for 46.7 percent intervention was ineffective.

More startling perhaps, was the observation that 3 or 20.0 percent of the children, for whom only six months or less expired between the two reports, were either seriously harmed in the more current of the two incidents or in both incidents.

Characteristics of Children in Two-Report Cases by Seriousness of Harm.–There was a general pattern observed for those children not seriously harmed in the current incident, and those seriously harmed in both incidents. Among the cases in which neither incident involved serious harm, only 3 or 20.0 percent involved black children; 12 or 80.0 percent involved white children. In regard to age, 11 or 73.3 percent were less than six years old. Only 1 or 6.7 percent was between the age of six and ten, and 3 or 20.0 percent were ten or above with all three being between age fourteen and sixteen.

Among the cases in which serious harm was perpetrated in both incidents, there were 3 or 33.3 percent black children and 4 or 66.7 percent white children. A much higher percent of these children were in the youngest age categories. Five or 83.4 percent were less than six years of age; only 1 or 16.6 percent was ten years or above.

An observation on the type of abuse suffered by the children is also noteworthy. Among the cases in which neither incident involved serious harm, in only 20.0 percent of the cases was physical abuse perpetrated in one of the incidents. The occurrence of physical abuse in both incidents was noted in a similar percentage of the cases. There was a percentage increase in physical abuse among the cases in which harm was more serious in the current incident–37.5 percent physical abuse in one incident and 25.0 percent in both incidents. The same general pattern held in the cases in which harm was serious in both incidents–33.3 percent physical abuse in one incident and 33.3 percent in both incidents. Thus, it appears that cases involving serious harm to the child were more likely those in which physical harm was inflicted.

Three-Report Cases

Seriousness of harm for all incidents, in cases on which there were three reports, was known in twenty cases. In 10 or 50.0 percent of these cases, harm to the child was not serious in either of the three incidents; one case or 5.0 percent involved more serious harm in the earliest reported incident; 2 or 10.0 percent were more seriously harmed in the two earlier incidents.

Noting seriousness of harm from another perspective, we observed that 2 or 10.0 percent of the children were more seriously harmed in the current of the three incidents; 5 or 25.0 percent were seriously harmed in the two most current incidents; and 1 or 5.0 percent was seriously harmed in all three incidents.

Of the twenty three-report cases for which seriousness of harm was known for each incident, 5 or 25.0 percent of them were reported a second time in less than one year and were more seriously harmed in one or both of the most current incidents. Four or 20.0 percent of these cases involved all three incidents reported within a year's time; and in 2 or 10.0 percent all three incidents were reported within a period of six months.

Applying the criterion to cases first reported after December 31, 1972, we found that there were eleven three-report cases in this time period for which seriousness of harm was known for all three incidents. Of these 6 or 54.6 percent involved harm which was determined to be not serious in either of the three incidents. There were no cases in which harm was more serious in the earliest incident; in one case (9.1 percent) the harm perpetrated on the child was more serious in the two earlier incidents.

From the perspective of ineffectiveness, we found that one child (9.1 percent of the cases) was more seriously harmed in the current incident; 2 or 18.1 percent were more seriously harmed in the two most current incidents; and 1

or 9.1 percent was seriously harmed in all three reported incidents. Three or 27.3 percent of these children were reported three times within a period of one year.

Characteristics of Children in Three-Report Cases by Seriousness of Harm.–Among the cases in which none of the three incidents involved serious harm, there were 2 or 20.0 percent black children and 8 or 80.0 percent white children. In terms of age, only 1 or 10.0 percent was less than six. Five or 50.0 percent of these children were age six but less than ten, and 40.0 percent were ten or above. Physical abuse was observed in one of the three incidents in 4 or 40 percent of these cases. In none of the cases was physical abuse present in two or all three of the incidents.

Among the cases in which harm was more serious in one or both of the current incidents, 2 or 28.6 percent involved black children and 5 or 71.4 percent involved white children. These children tended to be younger than those who were not seriously harmed in either incident. Five or 71.5 percent were less than six years of age. One or 14.3 percent was age six but less than twelve.

A higher percent of these cases also involved physical abuse. In four cases (57.1 percent) physical abuse was observed in one of the three incidents. In 2 or 28.6 percent of these cases, physical abuse was present in two of the incidents; and in 1 or 14.3 percent, physical abuse was present in all three incidents.

Rehabilitation of Perpetrator as a Criterion

Two-Report Cases

The perpetrator was known in both incidents in 41 of the 42 cases on which two incidents had been investigated. In 35 or 85.4 percent of these cases, the perpetrator was the same in both incidents.

Beyond noting the perpetrator in the reported incidents, we looked at the type of abuse and/or neglect to which the child was exposed. Given the limitations discussed in an earlier section of this chapter, we found that in 20 or 47.6 percent of the 41 cases the type abuse and/or neglect remained the same in both incidents. In 19 or 46.3 percent of the cases the perpetrator and the type abuse were the same in both incidents.

Of the 35 perpetrators remaining the same for both incidents, 27 or 77.1 were mothers or other mother substitutes. Eight or 22.9 percent were fathers or other father substitutes. For all incidents in which fathers or father substitutes were involved, physical abuse was the form or one of the forms of maltreatment in approximately seventy percent of the reports. This compares to approximately twenty percent for mothers or mother substitutes.

Of the cases first reported after December 31, 1972, the perpetartor was known for both incidents in 22 cases. The perpetrator was the same in 19 or 86.4 percent, with 13 or 68.4 percent being mothers or mother substitutes and 31.6 percent being fathers or father substitutes.

The type abuse remained the same in both incidents in 11 or 50.0 percent of the cases.

Three-Report Cases

The perpetrator and type abuse were known in all of the 23 three-report cases. In 1 or 4.3 percent of the cases, the perpetrator was the same in the two most current incidents. In 15 or 65.2 percent of these cases, the perpetrator was the same in each of the three incidents. In 14 or 93.3 percent of the 15 cases in which the perpetrator remained the same in all three incidents, the mother or stepmother was indicated.

The type abuse was the same in all three incidents in 3 or 13.0 percent of the cases. In 5 or 21.3 percent of the cases, the type abuse was the same in the two most current incidents. Again, as in two-report cases, neglect and abuse unrelated to discipline were most likely to be the type of abuse to be the same in the two current or all three incidents.

The perpetrator and the type abuse were the same in the two most current incidents in 7 or 30.4 percent of the cases. In 4 or 17.4 percent of the cases, the perpetrator and the abuse were the same in all three incidents.

For the fourteen three-report cases first reported after December 31, 1972, in which the perpetrator was known in all incidents, the perpetrator was the same in 10 or 71.4 percent with the mother or mother substitute being indicated in every case. The type abuse was the same for each incident in 3 or 21.4 percent of the cases.

Disposition of the Agency as a Criterion

Two-Report Cases

The disposition of the agency for both incidents was known in 41 of the 42 two-report cases. In 20 or 48.8 percent of these cases, the disposition in the more current of two incidents was more severe than that made in the earlier report. In 3 or 7.3 percent of the cases, the disposition was severe in both incidents. From these combined data, we infer that intervention was ineffective in 56.1 percent of the cases.

Noting effectiveness, we found that in 15 or 36.6 percent of the cases, dispositions of a non-severe nature, e.g., remain in the home with services, remained unchanged for both incidents. For 3 or 7.3 percent of the cases, the disposition in the current of the two incidents was less severe than that made in the earlier incident.

We noted agency's disposition toward petitioning for removal in two-report cases. Whether or not a petition was filed was known in forty cases. In 3 or 7.5 percent of the cases, a petition was filed in the earlier incident but not in the current. A petition was filed in neither incident in 19 or 47.5 percent of the cases. From these data, we infer that intervention was effective.

Of more significance, however, was the high percent of cases in which a petition was filed in the current incident but not in the earlier one. This occurrence was noted in 13 or 32.5 percent of the cases (N=40). Similarly, a petition was filed in both incidents in 5 or 12.5 percent of the cases. More importantly, in 5 or 27.8 percent of the cases (N=18) on which a petition was filed in both incidents or in the most current of the two, the case was a re-entry into the system in less than six months.

Given the tendency for CES personnel to move toward more severe dispositions through time, we decided to note this tendency in relation to race, seriousness of harm, and age. Noting the trend in disposition by race, we found that a more severe disposition was made in the current incident in 17 or 58.6 percent and severe in both incidents in 2 or 6.5 percent of the 29 cases involving white children for whom the disposition was known for both incidents. This compares to a more severe disposition in the current incident in 2 or 18.2 percent of the 11 cases involving black children; and in no case was the disposition severe for both incidents.

Truly, if severe dispositions; e.g., emergency removal, petitioning, etc., are designed to immediately protect children in need, we can see that such protection was more imminent for white children.*

Thus, we asked the question of how the above findings stack up with seriousness of harm in mind. Of the 11 black children, 6 or 54.5 percent were determined to be seriously harmed in one incident (N=4) or in both (N=2). On the other hand, only 9 or 31.0 percent of the 29 white children (5 in one incident and 4 in both) were seriously harmed. Of the 6 black children who were seriously harmed, the agency made a more severe disposition in the current of the two incidents for 2 or 33.3 percent. Of the 9 cases in which white children were seriously harmed, a more severe disposition was made in 6 or 66.7 percent.

As to age, a more severe disposition in the current incident was made for the two black children less than age three. In one case, the child had been seriously harmed in the first incident but allowed to remain in the home with services. The second case involved serious physical harm in both incidents which occurred within a period of six months. Following the first incident, the child was allowed to remain in the home with services.

For white children, a more severe disposition was made in the current incident in 7 or 24.1 percent of the cases involving children under three years of age. In only one of these cases (14.3 percent) was the harm serious in both incidents. Harm was not serious in either incident in 2 or 28.6 percent of the cases. A more severe disposition was made in the current incident in 4 or 13.7 percent of the cases involving children between the age of six and ten and in 5 or 17.2 percent involving children fourteen and above. In the main the older children were determined not to be seriously harmed in either of the incidents.

We applied the criterion of agency disposition to two-report cases first reported after December 31, 1972. There were 22 cases in this time period for which the agency's disposition was known in both incidents. In 11 or 50.0 percent of these cases a disposition of a non-severe nature remained unchanged for both incidents. In none of the cases was the

*We did not note these tendencies in regard to the actual act of petitioning since the petitioning process was not a function CES assumed primarily for itself. We will speak to this matter in more detail in Chapter 6 in which we note the petitioner.

disposition in the current incident of a less severe nature than that made in the earlier incident. Thus, by this criterion applied to cases first reported approximately one year after the inception of CES, effectiveness of intervention was noted in 50.0 percent of the cases.

By the same logic, ineffectiveness was observed in 50.0 percent of the cases. In 10 or 45.5 percent of the cases in this time period, the agency's disposition in the current incident was more severe than that made in the earlier incident. The disposition was severe in one case or 4.5 percent for both incidents.

From the standpoint of the decision to petition for removal, however, CES realized a higher degree of success in cases first entering the system after December 31, 1972. A petition was filed in neither incident for 12 or 57.1 percent of the cases and in the earlier but not the current in one case or 4.8 percent. Thus, by these indicators, effectiveness was realized in 61.9 percent of the cases. Perhaps, the agency has begun to come to grips with more effective means other than petitioning.

A petition was filed in the current but not in the earlier incident in 6 or 28.6 percent of the cases, and in both incidents in 2 or 9.5 percent. Thus, ineffectiveness of intervention, as inferred from the act of petitioning for removal, was observed for 38.1 percent of the cases.

Three-Report Cases

In the three-report cases, the disposition was known in all three incidents in 23 cases. In only 5 or 21.7 percent of these cases did a disposition of a non-severe nature remain unchanged for all three incidents. In 2 or 8.6 percent of the cases, the disposition in the current incident was less severe than that made in the earliest incidents. Thus, effectiveness by this criterion in the three incident cases was observed in slightly less than one-third of the cases.

In 9 or 39.1 percent of the cases, the disposition in the current incident was more severe than in either of the prior incidents. In 1 case or 4.3 percent the disposition was severe in all three incidents, and in 4 or 17.4 percent of the cases the disposition was more severe in the two most current incidents.

In terms of the agency's tendency to move to petitioning for removal as the cases progressed in number of incidents, intervention by this criterion was also ineffective. In 9 or 39.1 percent of the cases, a petition was filed in the current but neither of the two earlier incidents. In 3 or 13.0 percent of the cases, a petition was filed in the two most current incidents, and in one case or 4.3 percent a petition was filed in all three incidents. More importantly, of the 12 cases on which a petition was filed in the most current or the two most current incidents, 3 or 25.0 percent were cases with less than six months between all three reports.

In regard to effectiveness by the criterion of petitioning, a petition was not filed in either of the incidents in 5 or 21.7 percent of the cases. In 2 or 8.7 percent, a petition was filed in only the earliest incident.

In submitting the criterion of agency disposition to cases which were first reported after December 31, 1972, we found that there were fourteen cases which were in this time period and for which the disposition was known in all three reported incidents. For the three-report cases in this time frame, CES was less effective as measured by this criterion than they were with two-report cases entering the system in this time period. In 6 or 42.8 percent of the cases, the disposition in the current incident was more severe than that made in either of the earlier incidents. In 2 or 14.3 percent, the disposition was more severe in the two most current incidents, and in 1 case or 7.1 percent the disposition was severe in all three incidents.

On the effectiveness side, in only 3 or 21.4 percent of the cases the disposition of a non-severe nature remained unchanged. In 1 case or 7.1 percent, the disposition in the current incident was less severe than the earliest and in a similar percent of the cases, the disposition in the current incident was less severe than in the two earlier ones.

In regard to petitions for removal in cases in this time period, i.e., approximately one year after the beginning date for the CES project, in 6 or 42.8 percent a petition was filed in the most current incident but not in either of the two earlier ones. In 1 case or 7.1 percent, a petition was filed in the two most current incidents, and in a similar percentage of the cases, a petition for removal was filed in all three incidents. Thus, by this criterion, the system was ineffective in its intervention in well over fifty percent of the cases.

Noting effectiveness by this criterion, a petition was not filed in either incident in 3 or 21.4 percent of the cases. In 1 case or 7.1 percent, a petition was filed in the earliest but not in the two most current incidents.

Effectiveness of Intervention in the PSU System

Recidivism as a Criterion

Of a total of 258 cases, 63 or 24.4 percent were cases on which at least one report prior to the most current had been made--serial abuse cases. Of the 63 serial abuse cases, 45 or 71.4 percent were cases on which only one prior report was made; 18 or 28.6 percent represented cases on which two or more incidents prior to the most current had been investigated.

Approximately one half of the serial abuse cases were deleted for the detailed individual case analyses due to the fact that reported incidents prior to the most current occurred prior to the study period--the beginning of the CES project.

Of the 31 serial abuse cases falling within the study period, 24 or 77.4 percent represented cases on which only one prior report had been investigated; 7 or 22.6 percent involved cases on which two or more prior reports were investigated.

Thus, in terms of recidivism in relation to the total PSU caseload slightly less than one-fourth (24.4 percent) of the cases involved re-entries. Noting recidivism among the 31 cases on which reports were first made after the period for which a determination of effectiveness is being made--August, 1971--we found that slightly less than twenty-five percent (22.6) of the cases had three or more reported incidents; 77.4 percent were involved in only one incident prior to the most current.*

Length of Time Between Incidents as a Criterion

Of the 31 cases reported within the study period, 17 or 54.8 percent were reported twice within the same year or within a year's time. Four or 12.9 percent were reported twice within a period of six months.

Two-Report Cases

Twenty-four of the 31 cases were those on which only one prior report had been made and documented. Of these, 12 or 50.0 percent were cases on which the two incidents were investigated within a period of six months.

Characteristics of Children in Two-Report Cases Who Re-entered the System Within a Year's Time.--Of the twelve children in the two-report cases who re-entered the system within a year's time, 4 or 33.3 percent were black and 8 or 66.7 percent were white.

In regard to age, 8 or 66.6 percent were less than six years of age. One child or 8.3 percent was between the age of six and eight and between ten and twelve. The age of two children (16.7 percent) was unknown.

In what ways did these children differ from those who did not re-enter the system within a year's time? Of a total of twelve such children, 7 or 58.3 percent were black and 5 or 41.7 percent were white. The children who did not re-enter the system within a year's time tended to be older than those who did. Only 6 or 50.0 were less than age six. One child or 10.0 percent was age six but less than ten. Forty percent of these children were ten years or older.

Three-Report Cases

There were only 7 cases in the PSU caseload for the study period on which two or more incidents prior to the most current were made. In 5 or 71.4 percent of these cases there was less than one year between each incident. In 1 or 14.3 percent, all 3 reports were made within a period of six months.

Characteristics of Children in Three-Report Cases Who Re-entered the System Within a Year's Time.--Five of the seven three-report cases represented children who were reported with less than one year between each incident. Of these five, 2 or 40.0 percent were black and 3 or 60.0

*Undoubtedly, part of the explanation for the low recidivism rate lies in the systems operations. Active cases, previously referred cases, or those not of an emergency nature were deflected from the PSU for the investigatory process and accordingly were not recorded in the PSU file. Beyond this, the record keeping further hampered the identification of the "true" picture of serial abuse. Generally, only one child abuse form would be included in the family folder even if a study of the folder revealed that several complaints had been investigated. See Johnson, *Two Community Protective Service Systems*, pp. 28-29 and 36-37.

percent were white. Only one child (20.0 percent) was less than one year old and two (40.0 percent) were age six but less than ten. Two children or 40.0 percent were ten years of age or above.*

Seriousness of Harm as a Criterion

Two-Report Cases

Seriousness of harm was known for both incidents in 21 of the 24 cases on which only one prior report was investigated. In 11 or 52.4 percent of these cases, the child was not harmed seriously in either of the two incidents. In 2 or 9.5 percent of the cases the child was more seriously harmed in the earlier incident. By utilizing seriousness of subsequent harm as a criterion, intervention was effective for over sixty percent of the cases.

Noting the criterion in relation to ineffectiveness of intervention, we determined that just under forty percent of the cases were so classified. In 4 or 19.0 percent of the cases, the harm perpetrated was more serious in the current of the two incidents. In a similar percentage, the harm was serious in both incidents.

We noted the seriousness of harm suffered by the children who re-entered the system in a period of less than one year. Of the 21 two-report cases for which seriousness of harm was determined in both incidents, 3 or 14.3 percent of the children were reported twice within the same year or within a year's time and were more seriously harmed in the current of the two incidents. Two or 9.5 percent were seriously harmed in both incidents. Thus, it appears that for 23.8 percent of the children who were involved in two incidents in a period of one year intervention, as inferred from the criterion of subsequent harm, was ineffective. Further, it was observed that in 2 or 9.5 percent of the cases, harm was serious in both incidents which were reported within a six month period.

Characteristics of Children in Two-Report Cases by Seriousness of Harm.--Among the two-report cases, there were eleven cases in which the harm was not serious in either of the incidents. Of these 5 or 45.5 percent were black and 6 or 54.5 percent were white. Regarding age, 6 or 54.5 percent were less than six and 5 or 45.5 were age ten and above.

Since there were only four children who were seriously harmed in the current of the two incidents and four who were seriously harmed in both, the discussion on characteristics refer to the combined group.* Among these children, fifty percent were black and fifty percent were white. Five or 62.5 percent were less than six years of age. Two or 25.0 percent were six but less than ten, and 1 or 12.5 percent was ten or over. Thus, it appears that a slightly higher percent of the black children were involved in incidents which had serious consequences. The children who were seriously harmed in one or both incidents tended to be younger than those who were not seriously harmed in either incident.

As with the seriousness of harm, there was also a pattern in the type of abuse for these groups of children. Physical abuse was more likely to be present in incidents involving serious harm than in those in which the harm was not serious. Among the eleven cases in which neither incident involved serious harm, in 4 or 36.3 percent of the cases one of the incidents involved physical abuse. None of the cases involved physical abuse in both incidents. On the other hand, in 2 or 50.0 percent of the cases in which the harm was more serious in the current incident physical abuse was perpetrated in both incidents; in one case physical abuse was noted in one of the incidents. Among the four cases in which serious harm occurred in both incidents, 75.0 percent were cases in which physical abuse was indicated in both incidents.

Three-Report Cases

In the seven cases in which there were three reports, seriousness of harm for all incidents was known. The data on these cases indicate a relatively high degree of success in intervention. In 3 or 42.9 percent of the cases, harm was not serious in either incident. In 2 or 28.6 percent, harm was more serious in the two earliest of the three incidents.

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*We have not analyzed cases in the PSU serial abuse caseload which were first reported after December 31, 1972. There were too few cases to make any meaningful analyses. As discussed earlier, the presumed partial explanation for this lies in the lack of efforts toward increased awareness and the system's intake procedure. A high percent of the total caseload were reported after the above time, but as isolated incident cases.

*There were two black and two white children among both groups of children, i.e., those seriously harmed in the current incident and those seriously harmed in both. Two children in the former group were less than six years of age and six to less than ten. In the latter group, three of the four were under six and one was ten or above.

Therefore, for 71.5 percent of the cases intervention, as inferred from this criterion, was effective in three-report cases.

Noting ineffectiveness of intervention, we found that harm was serious in all three incidents in only one case (14.3 percent) and in the same percentage, harm was serious in the two current incidents.

In regard to seriousness of harm and recidivism, there was only one case in which there was a year or less between incidents and the harm suffered by the child was serious in the two current incidents.

Characteristics of Children in Three-Report Cases by Seriousness of Harm.--Two of the children who were not seriously harmed in either incident were black; one was white. All three children were eight years of age and older. In only one case was physical abuse observed. There was one case each involved in incidents in which serious harm was observed in the two current incidents and in all three. Both children were white, with the one involved in the two incidents being ten years of age and the other being age four. In each case physical abuse was noted in each reported incident.

Rehabilitation of Perpetrator as a Criterion

Two-Report Cases

The perpetrator in both incidents was known in all of the 24 two-report cases. In 21 or 87.5 percent the perpetrator was the same in both incidents. Thus, by this criterion Savannah's PSU realized little success in case intervention.

Noting the type abuse perpetrated, it was determined that the type abuse remained the same in both incidents in 14 or 58.3 percent of the cases. The perpetrator and type abuse remained unchanged in 13 or 54.2 percent of the cases.

Eighteen or 85.7 percent of the cases in which the perpetrator was the same in both incidents involved the natural mother. In only three or 13.3 percent was the natural father the perpetrator. For all incidents in which fathers or father substitutes were involved, physical abuse was the form or one of the forms of abuse in well over seventy percent of the reports. By comparison, there were less than one-fourth of such incidents for mothers or mother substitutes.

The types abuse which were most likely to be the same in both incidents were neglect in six or 42.9 percent of the 14 cases, abuse unrelated to discipline in 4 or 28.6 percent, and abandonment in 3 or 21.4 percent.

Three-Report Cases

The perpetrator and type abuse were known for all three incidents in all seven of the three-report cases. In one or 14.3 percent of the cases the perpetrator was the same in the two most current incidents, and in four or 57.1 percent the perpetrator was the same in all three incidents. The type abuse was the same for the two most current incidents in one case (14.3 percent). In two or 28.6 percent of the cases, the type abuse was the same in all three incidents. The perpetrator and the type abuse were the same in all three incidents in two or 28.6 percent of the cases.

Disposition of the Agency as a Criterion

Two-Report Cases

The disposition for both incidents was known in all of the 24 two-report cases. In seven or 29.2 percent of the cases, the disposition in the current incident was more severe than that made in the earlier incident. There were no cases in which the disposition was severe in both incidents. The degree of ineffectiveness is determined from these data.

On the other hand, in 12 or 50.0 percent of the cases, dispositions of a non-severe nature remained unchanged in both incidents. In five or 20.8 percent, the disposition in the current incident was less severe than that made in the earlier incident. These data would suggest that in terms of agency disposition as a criterion, the PSU system realized a high degree of success.

Beyond the nature of agency dispositions, we noted the disposition to petition for removal in two-report cases. Whether or not a petition was filed was known in 23 cases. In 16 or 69.6 percent of the cases, a petition was not filed in either incident. In one case (4.3 percent) a petition was filed in the earlier but not in the current incident.

In five or 21.7 percent of the cases, a petition was filed in the current but not in the earlier incident. In one or 4.3 percent a petition was filed in both incidents. More importantly, in two or 33.3 percent of the above six cases on which a petition was filed in one or both of the incidents, the case was investigated both times within a period of six months or less.

There was not an overall tendency for PSU personnel to move toward more severe dispositions as cases progressed in number of reports. We noted that in seven or 29.2 percent of the cases the disposition was more severe than that made in the earlier incident. Were there factors common in such cases when this trend was observed? There were three black children and four white affected by this type dispositional process. In one case involving black children, both incidents involved serious harm; in another, serious harm was incurred in the second incident; and in the third both incidents which occurred within six months, involved harm which was not serious. For white children, a similar pattern existed; more severe dispositions in the current incident seemed to be made in cases having serious consequences for children in one or both incidents and/or both incidents occurred within a period of one year.

Similarly, there was a tendency for more severe dispositions in the earlier of the two incidents to have been made in cases involving serious harm. For these cases, harm was not serious and dispositions were less severe in the current incident. Of the 12 cases involving dispositions of a non-severe nature in both incidents (7 cases of black children and 5 of white) approximately two-thirds involved harm of a non-serious nature in both incidents.

Three-Report Cases

Agency disposition in the seven of the three-report cases was known for all three incidents. In only one case (14.3 percent) did a disposition of a non-severe nature remain unchanged for the three incidents. There were no cases in which the current disposition was less severe than that made in the two earlier incidents. Effectiveness of intervention by agency disposition in the three-report cases, therefore, was noted for less than fifteen percent of the cases.

In terms of the ineffectiveness of intervention by this criterion, there were three or 42.9 percent of the cases in which the disposition in the current incident was more severe than that made in either of the prior incidents. In one case or 14.3 percent the disposition was severe in all three incidents. In a similar percent of the cases, the disposition in the two most current incidents was more severe than that made in the earliest.

Regarding the agency's disposition to petition for removal in three-report cases, we found that of the six cases for which these data were known for the three incidents, only one or 16.7 percent did not involve a petition in either incident. There were no cases in which a petition was filed in the earliest incident but not in the one or two most current ones. On the other hand, there were two or 33.3 percent of the cases in which a petition was filed in the current incident but not in the two earliest ones.

Comparative Summary of the Effectiveness of Intervention

Criteria and Findings

- **Recidivism as a Criterion**

  The extent to which children did not return to the system as measured by the absence of subsequent reports was considered an indication of effectiveness of intervention.*

  The observed recidivism rate in Nashville's (CES) total caseload was approximately twice that found in Savannah's (PSU) caseload. In the CES caseload, 44.8 percent of the total caseload represented cases on which one or more prior reports had been made and investigated. By comparison, only 24.4 percent of the PSU caseload were serial abuse cases.

  Noting recidivism among the serial abuse cases, we found that a higher percent (36.5) of the CES cases represented those on which two or more incidents (excluding the most current) had been investigated. This compares to 28.6 percent of the PSU cases. These data are presented in Table 5-1.

  For detailed case analyses on effectiveness of intervention, the caseload in both systems was decreased significantly due to the number of cases in which reported incidents--prior to the most current within the series of incidents--occurred prior to August, 1971, the inception of the CES project. Thus, all two-and three-report cases, in which incidents prior to the current one were reported prior to that time, were totally deleted from detailed analyses of effectiveness.

  Thus, it appears from the data in Table 5-2 that the recidivism rate in the CES system for cases first reported

*Please review the major considerations presented in a previous section of this chapter for the interpretation and utilization of these and following data.

TABLE 5-1

Recidivism Rate

Protective Service System	Recidivism in the Total Caseload					Recidivism in Serial Abuse Cases*			
	Deck 1 (Serial Abuse)		Deck 2 (Isolated Incident)		Total	Deck 3 (Two Reports)		Deck 4 (Three Reports)	
	N	%	N	%		N	%	N	%
Nashville (CES)	104	44.8	128	55.2	232	66	63.5	38	36.5
Savannah (PSU)	63	24.4	195	75.6	258	45	71.4	18	28.6

*Decks 3 and 4 represent prior incidents of Deck 1, thus percentages are based on the number of cases in Deck 1.

TABLE 5-2

Recidivism Rate in Cases First Reported after August, 1971*

Protective Service System	Deck 3 (Two Reports)		Deck 4 (Three Reports)		Deck 1 (Total Serial Abuse Cases in Study Period)
	N	% of Deck 1	N	% of Deck 1	
Nashville (CES)	42	63.6	22	34.8	66
Savannah (PSU)	24	77.4	7	22.6	31

*Applies only to serial abuse cases utilized in individual case analyses of effectiveness of intervention.

after August, 1971 was higher than that for the PSU. Of the serial abuse cases within this period, 34.8 percent in the CES caseload and 22.6 percent in the PSU represented cases on which more than one prior incident had been reported.

● **Length of Time Between Incidents as a Criterion**

Longer periods of time between the re-entry of children into the system was considered a measure of effectiveness.

According to Table 5-3, 27 or 64.3 percent of the 42 two-report cases in the CES caseload represented the same children who were reported twice within the same year or within a year's time. Of the 27, 12 or 28.6 percent (N=42) were reported twice within a six month period. Twelve or 50.0 percent of the same children in

TABLE 5-3

Length of Time Between Incidents

	Cases with a year or less between reports		Cases with six months or less between reports		Cases in which all reports were made in six months or less*	
	N	%	N	%	N	%
Deck 3 (2 Reports)						
Nashville (CES) (N=42)	27	64.3	12	28.6	0	–
Savannah (PSU) (N=24)	12	50.0	3	12.5	0	–
Deck 4 (3 Reports)						
Nashville (N=24)	16	66.7	8	33.3	3	12.5
Savannah (N=7)	5	71.4	1	14.3	1	14.3

*Cases also included in those with six months or less between reports.

the PSU caseload were reported twice in the same year. In three or 12.5 percent of the cases, the child was reported twice within six months.

These data tend to indicate that while neither system realized a high degree of success by the criterion of time between incidents, children returned to the CES system more quickly than did those in the PSU.

Noting three-report cases, we observed less differences between the systems with respect to the percentage of the same children who returned to the system in the specified time periods. In the CES caseload, there were 16 or 66.7 percent of the cases in which a year or less elapsed between each of the three incidents. This compares to five or 71.4 percent in the PSU caseload. Eight or 33.3 percent involved cases in which only six months expired between each incident investigated by CES caseworkers. By comparison, one or 14.3 percent of such cases was investigated by PSU caseworkers. More importantly, three or 12.5 percent of the same children among the CES cases and one or 14.3 percent among the PSU cases were involved in all three incidents within a six month period.

In order to allow for problematic areas in case handling which undoubtedly were experienced during the early stages of the CES project, we analyzed the data in relation to cases first reported after December 31, 1972. Thus, by this date, the project had been in operation for well over a year's time.

By noting only cases first reported to the CES system after this time period, we found that by the length of time between incidents as a criterion intervention was even less effective. Well over eighty percent of the same children were reported twice within the same year or within a year's time. Six months or less elapsed between the two reports for 36.4 percent of the children. A year or less expired between each of three reports for 85.7 percent of the children who were involved in three or more incidents. Seven or 50.0 percent of the three incident cases involved six months or less between each incident. Two children or 14.3 percent were involved in all three incidents in six months or less. See Table 5-4 for these data.

TABLE 5-4

Length of Time Between Incidents in Cases First Reported to the CES System after December 31, 1972

	Cases with a year or less between reports		Cases with six months or less between reports		Cases in which all reports were made in six months or less	
	N	%	N	%	N	%
2 Report Cases (N=22)	19	86.4	8	36.4	0	--
3 Report Cases (N=14)	12	85.7	7	50.0	2	14.3

● **Seriousness of Subsequent Harm as a Criterion**

This criterion is predicated on the assumption that subsequent reported incidents would involve harm less serious in nature than prior incidents if intervention were effective.

Utilizing seriousness of subsequent harm as an indicator of effectiveness of intervention, we found that for a sizable number of the children intervention into their lives was not effective. According to Table 5-5, 8 or 26.7 percent of the children among the two-report cases in the CES caseload and four or 19.0 percent in the PSU were more seriously harmed in the current of two incidents. Six or 20.0 percent among the CES cases and four or 19.0 percent among the PSU cases were seriously harmed in both incidents. Thus, while neither system realized a great deal of success in regard to this criterion, a higher percent of the children re-entering the CES system were more seriously harmed in the current incident.

Noting Table 5-5 further there is a most important methodological issue which surfaces. These aggregated data tend to suggest an entirely different picture of ineffectiveness. Taking the data for the CES system for example we find that when the data are aggregated, the system's intervention was most ineffective given that 76.6 percent of the children were not seriously harmed in the earlier incident and only 53.3 percent were not seriously harmed in the current. The individual case analyses to which we referred earlier suggest less divergence between effectiveness and ineffectiveness. Succinctly, for 14 or 46.7 percent of the children, subsequent harm was serious, i.e., serious in the current of two incidents or in both.

We noted ineffectiveness in terms of seriousness of harm suffered by the children who were reported twice in less than one year. In the Nashville CES system, five or 16.7 percent of the children and two or 9.5 percent of those in the Savannah's PSU were seriously harmed in the current of the two incidents and were reported twice in less than one year; two or 6.7 percent of those in the CES were reported twice in less than six months. Four or 13.3 percent of the children in the CES system and two or 9.5 percent in the PSU were seriously harmed in both incidents which were reported twice in less than one year. Of these, three of 10.0 of the CES and two or 9.5 percent in the PSU were reported twice in less than six months. See Table 5-6 for these data.

TABLE 5-5

Seriousness of Subsequent Harm in Two Reported Incident Cases

	Individul Case Analyses							
	Not seriously harmed-Either Incident (Effectiveness)		More seriously harmed-Earlier Incident (Effectiveness)		More seriously harmed-Current Incident (In-effectiveness)		Seriously harmed-Both Incidents (In-effectiveness)	
	N	%	N	%	N	%	N	%
Nashville (CES) N=30	15	50.0	1	3.3	8	26.7	6	20.0
Savannah (PSU) N=21	11	52.4	2	9.5	4	19.0	4	19.0

	Aggregated Data Analyses							
	Earlier Incident				Current Incident			
	Not Serious		Serious		Not Serious		Serious	
	N	%	N	%	N	%	N	%
Nashville (CES) N=30	23	76.7	7	23.3	16	53.3	14	46.7
Savannah (PSU) N=21	15	71.4	6	28.6	13	61.9	8	38.1

TABLE 5-6

Seriousness of Subsequent Harm and Recidivism in Two Reported Incident Cases

	Serious Harm in Current Incident Cases Reported Twice in:				Serious Harm in Both Incidents Cases Reported Twice in:			
	< 6 mos.		< 1 year		< 6 mos.		< 1 year	
	N	%	N	%	N	%	N	%
Nashville (N=30)	2	6.7	5	16.7	3	10.0	4	13.3
Savannah (N=21)	0	-	2	9.5	2	9.5	2	9.5

In relation to cases for which there were three reports, both systems appeared to realize a higher degree of success in intervention. In regard to the criterion, eight or 40.0 percent of the twenty such cases in the CES system and only two or 28.6 percent in the PSU were either seriously harmed in all three incidents or more seriously harmed in one or both of the most current ones. These data, as well as data relevant to aggregated case analyses are presented in Table 5-7.

Noting effectiveness of intervention by the seriousness of subsequent harm criterion in cases first reported to the CES system after December 31, 1972, we found little difference than in the measured effectiveness for cases reported from the beginning of CES as an operating system. See Table 5-8.

● **Rehabilitation of Perpetrator as a Criterion**

To the extent that reported incidents did not involve the same perpetrator(s) and/or the same type abuse, we inferred that services were effective.

The data presented in Table 5-9 strongly suggest that, in regard to rehabilitation of perpetrator as the criterion, neither system intervened effectively. The perpetrator in two-report cases was the same in both incidents in 35 or 85.4 percent of the CES cases and in 21 or 87.5 percent of the PSU caseload.

Regarding the type abuse perpetrated on the children, the same type was involved in both incidents in 20 or 47.6 percent of the CES cases and in 14 or 58.3 percent of the PSU cases. The perpetrator and type abuse were the same in 19 or 46.3 and 13 or 54.2 percent of the CES and PSU cases, respectively.

It appears from the data in Table 5-10 that there was a smaller percent of cases in which the perpetrator, the type abuse, and/or both the perpetrator and type abuse remained the same in all incidents among the three-report cases. While this tendency was noted for both the CES and the PSU caseloads, it remained that a higher percent of cases in the PSU caseload involved the same type abuse and the same perpetrator.

● **Disposition of Agency as a Criterion**

This criterion is based on the assumption that dispositions in subsequent incidents would be less severe in nature than prior dispositions or remain non-severe over time.

According to the data presented in Tables 5-11 and 5-12 intervention by the PSU system in two-report cases was more effective than intervention by the CES system in similar types of cases. In Table 5-11, it can be seen that in 56.1 percent of CES cases, the disposition was severe in both incidents or in the current of the two incidents. This compares to only 29.2 percent of PSU cases. Similarly, in the same table it can be noted that dispositions in the current incident tended to move toward being less severe than that in the prior incident for the PSU cases--in three or 7.3 percent and in five or 20.8 percent

TABLE 5-7

Seriousness of Subsequent Harm in Three Reported Incident Cases

	Individual Case Analyses											
	Not Serious Either Incident (Effectiveness)		More Serious Earliest Incident (Effectiveness)		More Serious Two Earliest Incidents (Effectiveness)		Serious All Three Incidents Ineffectiveness)		More Serious Most Current Incident (Ineffectiveness)		More Serious Two Most Current Incidents (Ineffectiveness)	
	N	%	N	%	N	%	N	%	N	%	N	%
Nashville (CES) N=20	10	50.0	1	5.0	2	10.0	1	5.0	2	10.0	5	25.0
Savannah (PSU) N=7	3	42.9	0	—	2	28.6	1	14.3	0	—	1	14.3

	Aggregated Data Analyses											
	Earliest Incident				Second Incident				Current Incident			
	Not Serious		Serious		Not Serious		Serious		Not Serious		Serious	
	N	%	N	%	N	%	N	%	N	%	N	%
Nashville (CES) N=20	16	80.0	4	20.0	13	65.0	7	35.0	13	65.0	7	35.0
Savannah (PSU) N=7	4	57.1	3	42.9	3	42.9	4	57.1	5	71.4	2	28.6

TABLE 5-8

Seriousness of Subsequent Harm in Cases First Reported to the CES System after December 31, 1972

	Not Serious Either Incident (Effectiveness)		More Serious Earliest Incident (Effectiveness)		More Serious Two Earlier Incidents (Effectiveness)		More Serious Current Incident (Ineffectiveness)		Serious All Incidents (Ineffectiveness)		More Serious Two Current Incidents (Ineffectiveness)	
	N	%	N	%	N	%	N	%	N	%	N	%
2 Report Cases (N=15)	8	53.3	0	--	0	--	3	20.0	4	26.7	0	--
3 Report Cases (N=11)	6	54.6	0	--	1	9.1	1	9.1	1	9.1	2	18.1

TABLE 5-9

Perpetrator and Type Abuse in Two Reported Incident Cases

	Perpetrator Same Both Incidents		Type Abuse Same Both Incidents		Perpetrator and Type Abuse Same Both Incidents	
	N	%	N	%	N	%
Nashville (CES) (N=41)	35	85.4	20	47.6	19	46.3
Savannah (PSU) (N=24)	21	87.5	14	58.3	13	54.2

TABLE 5-10

Perpetrator and Type Abuse in Three Reported Incident Cases

	Same all Three Incidents		Same Two Most Current Incidents	
	N	%	N	%
Perpetrator				
Nashville (N=23)	15	65.2	1	4.3
Savannah (N=7)	4	57.1	1	14.3
Type Abuse				
Nashville	3	13.0	5	21.3
Savannah	2	28.6	1	14.3
Perpetrator and Type Abuse				
Nashville	3	13.0	0	-
Savannah	2	28.6	0	-

of the CES and the PSU caseloads the disposition in the current incident was less severe than that made in the earlier of the two incidents.

The agencies disposition toward petitioning for removal is presented in Table 5-12. It can be seen that both systems moved in the direction of petitioning in the current incident. However, the tendency was less marked in the PSU system. Of significance is the high percent of CES cases (32.5) in which a petition was filed in the current but not the prior incident. By comparison, 21.7 percent of PSU cases were so classified.

Aggregated data analyses of dispositions and petitions for removal are also included in tabular form in the appropriate tables.

The agencies' dispositions in three-report cases are presented in Table 5-13. By these data it appears that neither system was effective; however, the CES system realized more success, by this criterion, than did the PSU system in multiple report/incident cases. In regard to measures inferring ineffectiveness of intervention, in over sixty percent of the cases in the CES caseload (60.8 percent) and slightly more than seventy percent in the PSU caseload (71.5 percent) the disposition was either severe in all three incidents or moved toward being of a severe nature in the current or two more current incidents. Aggregated data analyses are also presented in the Table.

Regarding agency tendency to petition for removal in three-report cases, we found no particular pattern among the six cases for which the data were known in the PSU caseload. Among the CES cases, there was a definite tendency for the agency to move toward petitioning in incidents subsequent to the first reported incident. In one case or 4.3 percent, a petition was filed in all three incidents; in nine or 39.1 percent a petition was filed in the current but neither of the two earlier incidents; and in three or 13.0 percent a petition was filed in the two more current incidents. For these and aggregated data analyses see Table 5-14.

For the sample of cases which was first reported to the CES system after December 31, 1972, we found among the two-report cases that effectiveness of intervention was similar to that found when we observed cases reported from the outset of the CES project as an operating system. Among the two-report cases in this later time period, the tendency remained for the agency to move toward severe dispositions as cases progressed in incidents. In ten cases or a high of 45.5 percent of these cases the disposition in the current incident was more severe than that made in the earlier incident. While dispositions became more severe, the agency was less likely after this later time period to move for a petition for removal. See Table 5-15.

There was little difference between the agency's dispositional stance among three reported incident cases during this later time period than among such cases handled from the beginning of the CES project. In general, intervention was somewhat ineffective by this criterion. In six or 42.8 percent of the fourteen cases, the disposition in the current incident was more severe than the ones made in the two earlier incidents. The disposition in the two more current incidents was more severe than in the earliest in two or 14.3 percent of the cases; and in one case or 7.1 percent the disposition was severe in all three incidents. Similar findings were observed in relation to petitions filed. See Table 5-16.

TABLE 5-11

Disposition of Agency in Two Reported Incident Cases

	Individual Case Analyses							
	Disposition of a non-severe nature both incidents (Effectiveness)		Disposition less severe in current incident (Effectiveness)		Disposition severe both incidents (Ineffectiveness)		Disposition more severe in current incident (Ineffectiveness)	
	N	%	N	%	N	%	N	%
Nashville (CES) N=41	15	36.6	3	7.3	3	7.3	20	48.8
Savannah (PSU) N=24	12	50.0	5	20.8	0	--	7	29.2

	Aggregated Data Analyses							
	Earlier Incident				Current Incident			
	Severe		Not Severe		Severe		Not Severe	
	N	%	N	%	N	%	N	%
Nashville (CES) N=41	5	12.2	36	87.8	21	51.2	20	48.8
Savannah (PSU) N=24	5	20.8	19	79.2	6	25.0	18	75.0

TABLE 5-12

Petition for Removal in Two Reported Incident Cases

	Individual Cases Analyses							
	Petition filed in neither incident (Effectiveness)		Petition filed in earlier incident (Effectiveness)		Petition filed in both incidents (Ineffectiveness)		Petition filed in current incident (Ineffectiveness)	
	N	%	N	%	N	%	N	%
Nashville (CES) N=40	19	47.5	3	7.5	5	12.5	13	45.0
Savannah (PSU) N=23	16	69.6	1	4.3	1	4.3	5	21.7

	Aggregated Data Analyses			
	Earlier Incident Petition was filed		Current Incident Petition was filed	
	N	%	N	%
Nashville (CES) N=40	8	20.0	18	45.0
Savannah (PSU) N=23	2	8.7	6	26.1

TABLE 5-13

Disposition of Agency in Three Reported Incident Cases

	Individual Case Analyses											
	Disposition of a non-severe nature all three incidents (Effectiveness)		Disposition in current less severe than earliest (Effectiveness)		Disposition in current less severe than two earlier (Effectiveness)		Disposition severe all three incidents (Ineffectiveness		Disposition in current more severe than two earlier (Ineffectiveness)		Disposition in two current more severe than earliest (Ineffectiveness)	
	N	%	N	%	N	%	N	%	N	%	N	%
Nashville (CES) N=23	5	21.7	2	8.6	0	--	1	4.3	9	38.1	4	17.4
Savannah (PSU) N=7	1	14.3	0	--	0	--	1	14.3	3	42.9	1	14.3

	Aggregated Data Analyses											
	Earliest Incident				Second Incident				Current Incident			
	Non-severe		Severe		Non-severe		Severe		Non-severe		Severe	
	N	%	N	%	N	%	N	%	N	%	N	%
Nashaville (CES) N=23	18	78.3	5	21.7	18	78.3	5	21.7	8	34.8	15	65.2
Savannah (PSU) N=7	6	85.7	1	14.3	3	42.9	4	57.1	3	42.9	4	57.1

TABLE 5-14

Petition for Removal in Three Reported Incident Cases

	Individual Case Analyses											
	Petition filed neither incident (Effectiveness)		Petition filed earliest incident (Effectiveness)		Petition filed two earlier incidents (Effectiveness)		Petition filed all three incidents (Ineffectiveness)		Petition filed in current incidents (Ineffectiveness)		Petition filed in two current incidents (Ineffectiveness)	
	N	%	N	%	N	%	N	%	N	%	N	%
Nashville (CES) N=23	5	21.7	2	8.7	0	--	1	4.3	9	39.1	3	13.0
Savannah (PSU) N=6	1	16.7	0	--	0	--	0	--	2	33.3	0	--

	Aggregated Data Analyses					
	Earliest Incident Petition was filed		Second Incident Petition was filed		Current Incident Petition was filed	
	N	%	N	%	N	%
Nashville (CES) N=23	5	21.7	5	21.7	15	65.2
Savannah (PSU) N=6	1	16.7	3	50.0	3	50.0

TABLE 5-15

Disposition of Agency in Two Reported Incident Cases First Reported to the CES System after December 31, 1972

	Dispositions							
	Disposition of a non-severe nature both incidents (Effectiveness)		Desposition less severe current incidents (Effectiveness)		Disposition severe both incidents (Ineffectiveness)		Disposition more severe current incident (Ineffectiveness)	
	N	%	N	%	N	%	N	%
N=22	11	50.0	0	--	1	4.5	10	45.5
	Petitions Filed							
	Petition filed neither incident (Effectiveness)		Petition filed earlier incident (Effectiveness)		Petition filed both incidents (Ineffectiveness)		Petition filed current incident (Ineffectiveness)	
	N	%	N	%	N	%	N	%
N=21	12	57.1	1	4.8	2	9.5	6	28.6

TABLE 5-16

Disposition of Agency in Three Reported Incident Cases First Reported to the CES System after December 31, 1972

	Dispositions											
	Disposition non-severe all three incidents (Effectiveness)		Disposition current incident less severe than earliest (Effectiveness)		Disposition current incident less severe than two earlier (Effectiveness)		Disposition severe all three incidents (Ineffectiveness)		Disposition in current more severe than two earlier (Ineffectiveness)		Disposition in two more current more severe than earliest (Ineffectiveness)	
	N	%	N	%	N	%	N	%	N	%	N	%
N=14	3	21.4	1	7.1	1	7.1	1	7.1	6	42.8	2	14.3
	Petitions filed											
	Petition filed neither incident (Effectiveness)		Petition filed earliest incident (Effectiveness)		Petition filed two earlier incidents (Effectiveness)		Petition filed all three incidents (Ineffectiveness)		Petition filed in current incident (Ineffectiveness)		Petition filed two current incidents (Ineffectiveness)	
	N	%	N	%	N	%	N	%	N	%	N	%
N=14	3	21.4	1	7.1	0	--	1	7.1	6	42.8	1	7.1

Chapter 6

TOWARD IMPROVING THE DELIVERY OF CHILD PROTECTIVE SERVICES

We have presented data on two protective service delivery systems in two volumes–the earlier being concerned with the evaluation of systems operations and the present involving an analysis of systems input and output elements. More importantly, the present volume has also been devoted to a comparative evaluation of the effectiveness of the systems' intervention.

Having completed the task of presenting and discussing the data, the first inclination for ending the total enterprise was to "shoot from the shoulder" and simply proclaim that all was in vain. Intervention simply did not work; for a large percentage of the children and families, intervention was a futile undertaking.

But such a stance is defeatist and unwarranted for it doesn't take under consideration one of the pitfalls of evaluation research; namely, the failure to ask the question of working for what. Nor does it move us toward our major goal of providing possible insights for improvements, if indicated, in the delivery of child protective services.

Perhaps, then, the best format for this chapter is a presentation of the goals/criteria we imposed for the evaluation of effectiveness, evidence supporting the degree to which the systems met the criteria, and factors we considered to contribute to the success or lack of it.

To accomplish this task, in some instances we have introduced data not previously discussed; we have incorporated findings from the first volume; and we have included insights gained through the conduct of the research. More importantly, we have ended the chapter with our thinking about the need for improvements in service delivery.

Presentation of the Evidence

The following summarization of findings is presented as evidence for your consideration. This summarization is based on details resulting from the individual case analyses of our *sample of serial abuse cases which were reported to the agencies between August, 1971 and April, 1974*. See Chapter 5 for detail findings. There has been no effort in this section on evidence to point out differences between the systems with respect to the findings.

Recidivism as a Criterion

- Did the systems' intervention keep children from re-entering the systems?

  In both systems, a relatively high percent of the cases in the total caseload involved children who had been reported and investigated one or more times prior to the most current incident (44.8 percent of the CES total caseload and 24.4 percent of the PSU were serial abuse cases).

  Among the serial abuse cases in the total caseload, slightly more than one-third of the CES cases and just under thirty percent of those in the PSU represented cases on which two or more prior incidents had been reported.

  Of all cases which were investigated during the time frame for the evaluation of effectiveness–August 31, 1971 through April, 1974–slightly more than one-third of those in the CES system and slightly more than one-fifth of those in the PSU were reported and investigated at least three times during that period.

Length of Time Between Reported Incidents as a Criterion

- Did children remain out of the systems for a sufficient amount of time–more than one year–before their re-entry?

  Fifty percent or more of the serial abuse cases in both systems' caseload–sample of cases for individual case analyses–involved the same children who were reported twice within a year's time.

  A sizeable proportion of the children were reported twice within a six month period.

Severity of Subsequent Harm as a Criterion

- Was harm suffered by children in subsequent reported incidents not serious if serious in earlier incidents or not serious in either incident?

  In both systems' sample of serial abuse cases, a relatively high percent of the cases involved children who were more seriously harmed in the current incident or seriously harmed in all of the reported incidents.

  About half of the children who were more seriously harmed in the current incident or seriously harmed in all of the reported incidents were involved in two or more incidents within a period of one year or less.

Rehabilitation of Perpetrator as a Criterion

- Were the same perpetrator and type abuse involved in subsequent reported incidents?

  The same perpetrator(s) was involved in all reported incidents in approximately eighty percent of the cases in both systems' sample of serial abuse cases.

  The type abuse remained the same in all incidents in approximately one-half of these cases. The perpetrator and type abuse were the same in about half of the cases.

Disposition of Agency as a Criterion

- Did the dispositional stance in cases move in a direction which would appear to have less "severe" consequences for children and families?

  There was a tendency for both systems to move toward more severe dispositions as cases progressed in terms of reported incidents.

  In a relatively high percent of the cases, a petition was filed in the current incident only.

  A sizeable proportion of the cases, involving a move toward more severe dispositions, involved children who re-entered the systems in a short period of time.

Contributing Factors

Undoubtedly, when there is evidence of success or the lack of it, there must be factors assumed to contribute to that finding. Major problems, which we feel contributed to the state of the aforementioned evidence, have been identified. To elucidate the problems, data from the total research effort have been incorporated.

For ease of presentation the problems, as we view them, will be discussed as facets of broad problematic areas, as follows:

1) systems operations,
2) the dispositional process--agency and court, and
3) the case handling process or delivery of services.

Systems Operations

The way the systems operated, specifically in terms of the internal mechanisms for initial case handling appeared to influence system outcome. Beyond this, specific operations which contributed to the observed differences between the systems' outcome were noted. The following discussion, however, is geared to the operations which tend to explain differences, with operations specific to a given system being integrated in the discussion.

We noted that the recidivism rate among CES cases was considerably higher than that found among PSU cases. Perhaps, several factors, while not explaining the high rate in the CES system, contributed to the observed differences in the two systems.

The CES system provided for 24-hour intake which was a coordinated and cooperative venture with the Juvenile Court intake. Intake in the PSU was provided during the workday of the work week. There was virtually no coordination between the PSU and intake channels in the several systems.

Reportedly, CES personnel investigated *all* complaints which could not be referred to other community resources or otherwise deflected from CES. On the other hand, PSU personnel indicated that *most* abuse complaints were investigated, while a relatively large percent of neglect complaints were not.

Beyond intake provisions and reported coverage, the systems differed in their procedures for case documentations. Protective service cases which were not designated the proper domain in the PSU were not recorded on the Unit's log.

Given that complaints considered not serious, previously reported and not serious, and/or on active clients were deflected out of the unit, a picture of serial abuse could not be obtainable from this source. The above procedures suggest that the "true" reported incidence of child abuse and neglect was not reflected and isolated incident cases could have well been serial abuse cases.* Reportedly, all complaints to CES intake, regardless of the nature of the harm and the prior history of the child involved, were duly recorded.

All of the factors associated with the differences in recidivism rate could well apply to any differences noted between the two systems in regard to the length of time children remained out of the systems.

Beyond the preceding factors, the decidely different levels of community awareness and the extent of child abuse and neglect related activities in the two sites may have contributed both to the differences observed in recidivism rates as well as in the length of time between incidents.

Prior to the initiation of the CES project in Nashville, Davidson County, Tennessee, efforts were made both to gain awareness and legitimacy for the new program. There were no identified concerted efforts toward the coordination of protective service activities with the external environment in Savannah, Chatham County, Georgia.

At this point, we might introduce new data which may partially explain the existence of a higher percent of serious cases in the CES total caseload–approximately one-third of the cases in the CES caseload as compared to approximately one-fourth in the PSU.

According to Table 6-1, we note that a decidely lower percent of the cases in the PSU cases were reported by medical personnel. Beyond this, school personnel, who as yet have not become one of the most frequent reporting sources and who are probably more likely to report children only when they appear to be somewhat seriously affected by maltreatment, were the source of the complaint in a higher percent of the cases in the CES total caseload.

A routinized response set, which is not guided by such relevant variables as age of child and seriousness of harm, would seem to limit a system's effectiveness in the service delivery process. Noted in Table 6-2 is the response pattern for both systems.

In general, CES responded more quickly to serial abuse cases than to isolated incident cases. Regarding seriousness of harm perpetrated, a higher percent of the cases in the isolated incident caseload involved serious harm to the child. We asked ourselves if seriousness of harm was an influencing factor in the investigatory process. According to the data in Table 6-2, it appears that the most important criterion for prompt investigation was that of seriousness in serial abuse cases. While an overall 80.2 percent of these cases were investigated in less than twenty-four hours, 86.2 percent of the serious and 77.2 percent of the not serious were investigated in that time period. There was no real difference between the time of intervention in serious and not serious isolated incident cases--77.3 and 7 percent, respectively.*

PSU personnel responded to a higher percent of serial abuse cases in less than twenty-four hours; however, investigation appeared to be influenced both by seriousness and knowledge of the case, i.e., serial and isolated incident. Investigation was initiated in less than twenty-four hours in 73.3 percent of the serious cases in the serial abuse caseload and in 75.0 percent of those in the isolated incident caseload. Of the cases which did not involve serious harm to the child, 67.6 percent of those in the serial abuse caseload and 61.2 percent in the isolated incident caseload were investigated in less than twenty-four hours.

Noting Table 6-3, one observes that in general CES responded more quickly to cases involving the oldest groups of children among both types of cases. How did this response pattern reflect sensitivity to seriousness of harm suffered by the different age categories of children? Among both types of cases, approximately seventy percent of the serious cases involved children less than six years of age. On the other hand, less than twenty percent of the cases involving children ten and above were serious in nature.

Given the fact that the youngest groups of children are more likely than the oldest groups of children to suffer serious harm, coupled with a bit of input knowledge also revealed

*This was found to be a fact as Institute personnel conducted indepth studies of case data. Only one complaint form was in the family folder, while careful study revealed instances of repeated reports made and investigated. Beyond this, cases which were not documented in the Unit's log were not studied.

*These percentages were reversed in the earlier monograph. Correction should be made in Johnson, *Systems Operations*, p. 21.

TABLE 6-1

Agency/Person Making the Complaint

Agency/Person Making Complaint	Savannah (PSU)				Nashville (CES)			
	Serial Abuse		Isolated Incident		Serial Abuse		Isolated Incident	
	N	%	N	%	N	%	N	%
One or both parents	4	6.4	17	8.7	9	8.6	16	12.6
Probation officer	0	–	1	0.5	0	–	1	0.8
Child (self)	2	3.2	2	1.0	9	8.6	7	5.5
Police	10	16.1	30	15.4	16	15.4	22	17.2
School personnel	3	4.8	13	6.7	11	10.6	10	7.8
Juvenile Court	0	–	2	1.0	3	2.9	7	5.5
DPW	7	11.3	14	7.2	1	1.0	0	–
Other relative living with child	5	8.1	8	4.1	0	–	9	7.1
Relative not living with child	9	14.5	36	18.5	16	15.4	7	5.5
Neighbor/citizen	15	24.2	55	28.2	23	22.1	18	14.1
Private physician	0	–	4	2.1	1	1.0	0	–
Hospital personnel	1	1.6	4	2.1	9	8.6	19	15.0
Foster parent	1	1.6	0	–	0	–	0	–
Other	5	8.1	9	4.6	6	5.8	12	9.4
Total	62		195		104		128	

in Table 6-3; namely, the youngest groups make up the better portion of the total caseload, it appears that the response set would be more effective were the pattern based on age and seriousness of harm. Perhaps, part of the routinization observed in the pattern of responding could be attributed, in part, to the necessity of CES to investigate the majority of the cases reported at intake and the extremely large ongoing caseload they handled. At the time of the study, intra-agency cooperation was at such a low ebb that cases decidedly not of a crisis nature were not readily deflected from the CES project to the parent agency.

For the PSU serial abuse cases, it can be noted in Table 6-4 that cases involving children under the age of six were investigated more expediently than were cases involving the oldest groups of children--78.9 percent of the under six and 61.1 percent of the ten and above were investigated within twenty-four hours of the report. On the other hand, there was little difference between the percent of cases of children in the isolated incident caseload under the age of six and those of children ten and above which were investigated within twenty-four hours.

Clearly, the age of the child among serial abuse cases influenced the response pattern of the PSU. This observation was not observed in the isolated incident caseload. We noted earlier that slightly more than fifty percent of the serious cases in both the serial abuse and the isolated incident caseloads involved children under the age of six. On the other hand, the children ten and above accounted for slightly more than one-fourth of the serious cases in the serial abuse caseload and for more than one-third in the isolated incident caseload.

Dispositional Process: The Agency

The evidence tends to indicate that the decision-making process which, in part, guides case actions at specific

TABLE 6-2

Time Between Report of Incident and Investigation by Seriousness of Harm

Time	Savannah (PSU)								Nashville (CES)							
	Serial Abuse				Isolated Incident				Serial Abuse				Isolated Incident			
	Not Serious		Serious		Not Serious		Serious		Not Serious		Serious		Not Serious		Serious	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
< 24 hours	23	67.6 (67.6)	11	32.4 (73.3)	79	70.5 (61.2)	33	29.5 (75.0)	44	63.8 (77.2)	25	36.2 (86.2)	47	58.0 (79.7)	34	42.0 (77.3)
1 day < 2	3	75.0 (8.8)	1	25.0 (6.7)	15	78.3 (11.6)	3	16.7 (6.8)	5	71.4 (8.8)	2	28.6 (6.9)	5	55.6 (8.5)	4	44.4 (9.1)
2 days < 1 week	3	75.0 (8.8)	1	25.0 (6.7)	12	70.6 (9.3)	5	29.4 (11.4)	5	71.4 (8.8)	2	28.6 (6.9)	3	60.0 (5.1)	2	40.0 (4.5)
1 week < 1 month	3	75.0 (8.8)	1	25.0 (6.7)	14	93.3 (10.9)	1	6.7 (2.3)	3	100.0 (5.3)	0	--	4	57.1 (6.8)	3	42.9 (6.8)
1 month or more	2	66.7 (5.9)	1	33.3 (6.7)	9	81.8 (7.0)	2	18.2 (4.5)	0	--	0	--	0	--	1	100.0 (2.3)
Total	34	69.4	15	30.6	129	74.6	44	25.4	57	66.3	29	33.7	59	57.3	44	42.7

Attrition in the total N in this table is due to the exclusion of unknown.

TABLE 6-3

Time Between Report of Incident to CES and Investigation by Age

Time	Serial Abuse										Isolated Incident									
	<3		3<6		6<10		10<14		14<18		<3		<6		6<10		10<14		14<18	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
< 24 hours	18	23.7 (75.0)	18	23.7 (75.0)	16	21.1 (76.2)	12	15.8 (80.0)	12	15.8 (85.7)	40	44.9 (80.0)	15	16.9 (71.4)	14	15.7 (73.7)	9	10.1 (81.8)	11	12.4 (91.7)
1 day < 2	3	30.0 (12.5)	2	20.0 (8.3)	2	20.0 (9.5)	2	20.0 (13.3)	1	10.0 (7.1)	3	27.3 (6.0)	4	36.4 (19.0)	3	27.3 (15.8)	1	9.1 (9.1)	0	--
2 days < 1 week	3	37.5 (12.5)	3	37.5 (12.5)	1	12.5 (4.8)	0	--	1	12.5 (7.1)	3	60.0 (6.0)	1	20.0 (4.8)	0	--	0	--	1	20.0 (8.3)
1 week < 1 month	0	--	1	33.3 (4.2)	1	33.3 (4.8)	1	33.3 (6.7)	0	--	4	57.1 (8.0)	0	--	2	28.6 (10.5)	1	14.3 (9.1)	0	--
1 month or more	0	--	0	--	1	100.0 (4.8)	0	--	0	--	0	--	1	100.0 (4.8)	0	--	0	--	0	--
Total	24	24.5	24	24.5	21	21.4	15	15.3	14	14.3	50	44.2	21	18.6	19	16.8	11	9.7	12	10.6

TABLE 6-4

Time Between Report of Incident to PSU and Investigation by Age

Time	Serial Abuse										Isolated Incident									
	<3		3<6		6<10		10<14		14<18		<3		3<6		6<10		10<14		14<18	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
< 24 hours	8	21.6 (80.0)	7	18.9 (77.8)	11	29.7 (73.3)	6	16.2 (60.0)	5	13.5 (62.5)	40	34.2 (57.1)	24	20.5 (75.0)	24	20.5 (66.7)	17	14.5 (65.4)	12	10.3 (60.0)
1 day < 2	1	25.0 (10.0)	0	--	2	50.0 (13.3)	0	--	1	25.0 (12.5)	10	55.6 (14.3)	1	5.6 (3.1)	3	16.7 (8.3)	1	5.6 (3.8)	3	16.7 (15.0)
2 days < 1 week	1	25.0 (10.0)	0	--	1	25.0 (6.7)	1	25.0 (10.0)	1	25.0 (12.5)	8	44.4 (11.4)	1	5.6 (3.1)	4	22.2 (11.1)	4	22.2 (15.4)	1	5.6 (5.0)
1 week < 1 month	0	--	1	25.0 (11.1)	0	--	3	75.0 (30.0)	0	--	7	36.8 (10.0)	3	15.8 (9.4)	3	15.8 (8.3)	3	15.8 (11.5)	3	15.8 (15.0)
1 month or more	0	--	1	33.3 (11.1)	1	33.3 (6.7)	0	--	1	33.3 (12.5)	5	41.7 (7.1)	3	25.0 (9.4)	2	16.7 (5.6)	1	8.3 (3.8)	1	8.3 (5.0)
Total	10	19.2	9	17.3	15	28.8	10	19.2	8	15.4	70	38.0	32	17.4	36	19.6	26	14.1	20	10.9

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junctures of the protective service process was fraught with inconsistencies and lack of consideration of client input.

Case dispositions, as reflected in aggregated data analyses, often appeared unwarranted by the circumstances of the case. Seriousness of harm appeared to serve as only a minor guide in CES decision-making processes. There were minimal differences made between dispositions in cases involving serious and non-serious harm in the serial abuse caseload. Just over thirty percent of the children in both categories of severity were allowed to remain in the home with services; approximately fifteen percent were removed on an emergency basis; the decision to petition for removal was made in approximately one-fourth of the non-serious cases and in slightly less than one-third of the serious cases.

While there were minimal differences in the dispositions made in non-serious cases in both the CES serial abuse and the isolated incident cases, isolated incident cases involving serious harm were less likely allowed to remain in the home, more likely removed on an emergency basis, and to have a petition filed on the behalf of the children.

Seriousness of harm appeared as a guide to the decision-making process in the case dispositions made by PSU caseworkers. In the serial abuse caseload, twice as many of the children (over fifty percent) who were not seriously harmed than those who were seriously harmed remained in their own home. Over twelve percent of the seriously harmed in comparison to approximately six percent of those who were not seriously harmed, were removed on an emergency basis. A petition for temporary removal was filed on the behalf of approximately one-third of the children who were seriously harmed and on less than twenty percent of those who were not seriously harmed. While the percentages differed, the above pattern was observed in the isolated incident caseload. In general, a higher percent of severe dispositions was made in serial abuse cases.

Noting agency dispositions by age, we observed a peculiar finding among CES serial abuse cases. The children fourteen and above and those less than three were the least likely allowed to remain in the home with services, were more likely removed on an emergency basis, and more likely to have the disposition to petition made on their behalf. Why were such dispositions made? Possibly for the younger group, it was the seriousness of harm suffered–over 50.0 percent. On the other hand, only one-fifth of the white and none of the black children in the oldest age category were seriously harmed. Beyond this, the oldest children were the most likely of all children to have only one prior reported incident and the least likely to have been involved in a prior official placement. Among the isolated incident cases, children between ten and fourteen were similarly affected; however, they were least likely seriously harmed. They tended, however, to have more than one prior reported incident and a placement history.

While a relatively high percent of the youngest age children in the PSU caseload were seriously harmed, there was a tendency for PSU to allow the youngest children to remain in the home even in serious cases. Beyond this general tendency, seriousness of harm appeared to serve as a criterion in relation to older age children.

One must question the reasoning behind the tendency to allow the youngest children, who were seriously harmed, to remain in the home while the seriously harmed oldest age children were more likely removed. Perhaps, the thinking is that the very young children need their own parent(s). This, I would not argue. On the other hand, in view of the fact that the behavior of older children is more likely to change during the placement period, and often in ways at variance to parental expectation, coupled with the fact that virtually nothing is done to rehabilitate parents during the duration of placement, the practice escapes me.

In noting agency dispositions in serial abuse cases, a previous placement appeared to have been a factor considered by PSU caseworkers in the decision-making process. Children with a placement history were less likely allowed to remain in the home with services and more likely to be removed on an emergency basis and to have a petition filed on their behalf.

On the other hand, there was no difference between the percent of the children with and without a placement history in the CES caseload who were allowed to remain in the home with services. The children who were not previously in placement were approximately three times as likely to be removed on an emergency basis. However, a petition for temporary removal was filed on a higher percent of the children with a placement history.

Dispositions in the CES system appeared to be out of line with apparent available resources. A petition for removal was filed in slightly more than fifty percent of CES serial abuse and isolated incident cases. This compared to a petition being filed in slightly more than one-third of PSU serial abuse cases and just over twenty percent of the isolated

incident cases. Of the children on whom a petition was filed in the CES system, 48.1 percent in the serial abuse caseload and 39.7 percent in the isolated incident caseload were placed in foster care. By comparison, 76.2 percent of the children in PSU serial abuse caseload and 59.0 percent of those in the isolated incident caseload were placed in foster care.

The above discussion would on the surface represent an argument for warehousing children into foster care. That has not been the intent. Rather, the intent has been to set the stage for a consideration of resources and/or alternatives in seeking removal in the dispositional process.

While a petition was filed on a high percent of the children in the two oldest age groups among CES cases, these children were the least likely placed in foster homes–only 37.5 percent of the ten to less than fourteen and 22.2 percent of the fourteen and older on whom a petition was filed in the serial abuse caseload were so placed. In the isolated incident caseload, a petition was filed on behalf of 92.9 percent of the younger group–ten to less than fourteen–and on 56.2 percent of those fourteen and over. However, only 23.1 percent of the former and 22.2 percent of the latter went into foster care.

Perhaps one explanation for the gap in the number of petitions filed in the CES system and the number of subsequent foster home placements lies in the extent to which the petitioning process was controlled by persons or agencies other than CES of DPW. According to Table 6-5, less than one-third of the petitions were filed by CES. While CES disposition may have been to petition in many cases, they operated on a policy of trying to get the complainant to file the petition. While this practice may have had some advantages, it is obvious that it had some negative effect on agency operations, namely, finding adequate placements for specific age groups of children on whom petitions were filed.

Reflecting on the findings from the individual case analyses presented in Chapter 5, we determined that there was a marked tendency toward more severe dispositions as cases progressed in terms of subsequent reported incidents in the CES system. We will speak to this issue in more detail in a subsequent section. It is only in relation to initial dispositional matters that we wish to allude to the above noted tendency at this point.

We asked each worker interviewed the following question, "If on the basis of your evaluation of a case, a petition

TABLE 6-5

Agency/Person Filing Petitions

Agency/Person Filing Petitions	Serial Abuse				Isolated Incident			
	CES		PSU		CES		PSU	
	N	%	N	%	N	%	N	%
One or both parents	5	10.2	0	–	12	11.3	0	–
Probation officer	1	2.0	0	–	1	1.6	1	2.6
Child (self)	1	2.0	0	–	1	1.6	0	–
Police	12	24.5	2	12.4	14	22.6	2	5.3
School personnel	0	–	0	–	0	–	0	–
Juvenile Court	4	8.2	0	–	6	9.7	2	5.3
DPW-DHR	16	32.7	11	68.8	20	32.3	31	81.6
Other relative living with child	0	–	1	6.3	4	6.5	1	2.6
Relative not living with child	4	8.2	2	12.4	4	6.5	1	2.6
Neighbor/citizen	5	10.2	0	–	0	–	0	–
Hospital personnel	0	–	0	–	1	1.6	0	–
Other	1	2.0	0	–	4	6.5	0	–

for removal of the child would seem to be in order, what, if anything in your current situation would hinder the agency from following through with a petition?" From a list of eight factors and the option of indicating other, they were asked to rank the factors in terms of importance to the question. Two of the CES workers indicated as the most important factor the agency's philosophy that it is preferable to retain a child in his own home; two additional workers indicated a strong belief in the family's ability to rehabilitate itself with services; and one indicated the flaws in the judicial process. We obtained this information for four workers in the PSU. Only one worker indicated that agency philosophy would hinder the petitioning process in view of findings mandating such. The unavailability of detention facilities and/or foster home placements was the major factor considered by the other workers.

If appropriate services are forthcoming, such a philosophy which evidently guided much of CES thinking would be laudable. However, in view of apparent inappropriate and/or inadequate services and the apparent lack of continued monitoring thereof, it would appear to be in the best interest of children, when circumstances so mandate, to rely more on reality factors.

Dispositional Process: The Court

Perhaps two of the most important elements in the adjudicatory and dispositional processes are the fit between the agency's case action and the court's dispositional stance and the criteria the court uses in rendering decisions.

Given the fact that the court process may be a traumatic experience for the children involved, it would appear that entry into the system would be based on more than "probable" cause and the last avenue to which the agency could resort to protect the child. All efforts to rehabilitate the parent(s) ideally would have been exhausted. If this were the case, there would appear to be few inconsistencies between the agency's recommendations and the court's dispositions. This was apparently not the case in terms of the court and CES. Of the children in the CES system on whom a petition was filed, 16.7 percent of those in the serial abuse caseload were returned to one or both parents; 23.7 percent of those in the isolated incident caseload were returned to the home. By comparison only 4.8 percent of the children in the PSU serial abuse caseload and 12.8 percent of those in the isolated incident caseload were returned to the home.

What criteria guided the court's dispositional stance? In both systems, placement history appeared to be a criterion. In neither system's serial abuse caseload were children with a placement history returned to one or both of the parents. This compares to over twenty percent so placed who had not been previously placed.

Seriousness of harm suffered by the child did not appear to be a determining factor in the court's decision-making process. In the CES caseload, there was little difference between the percent of children who were and were not seriously harmed in both types of cases who were returned to the home. In cases reported to the court by the PSU, the fact of having been previously reported appeared to be a more determining factor than the degree of seriousness of harm; only one of 21 children in the serial abuse caseload was placed with a parent. Among the isolated incident cases, a higher percent of the seriously harmed were returned to one or both parents.

In noting the court's disposition by circumstances present in families of children in the CES caseload, we found that a relatively high percent of the children were returned to the home where child related personal circumstances were present. Thinking back on the seriousness of harm by the presence of circumstances, the above pattern to the court's dispositions causes a degree of concern. Child related circumstances or conditions were among the very types of circumstances in which a high percent of the cases were serious in nature.

Among the PSU cases, we found that the highest percentages of the children were returned to the home when parent and/or family related circumstances were present. The highest percentage of children returned were those who lived in large families; the female parent exhibited sexual, alcohol, and/or drug problems, and the female parent was single and living with a man. Children were least likely returned to one or both parents when the child evidenced emotional or behavioral problems or when the father exhibited sexual, alcohol, and/or drug problems.

In relation to the seriousness of harm by the presence of specific familial circumstances, it appears that with a few exceptions, the court's disposition to return children to the home was not too incongruent with the findings regarding seriousness by the presence of specific circumstances.

Case Handling: The Staff

There can be no doubt that a sufficiently qualified staff

is needed to provide adequate child protective services to children and their families. Protective service workers need specialization, experience in the field, and on-going training. The staff of these two systems, as most, did not meet this ideal.

None of the workers in either system held the undergraduate degree in the area of social work/social welfare. In fact, four of the CES workers held their degree in a totally unrelated area. One of the PSU worker's degree was in an unrelated area. However, it is of import to note that workers whom we interviewed in the PSU were not long-term service providers. This function was the responsibility of generalists in another unit of the parent agency.

In terms of experience, workers in both systems tended to have less than three years of work experience in protective services and in the broader area of social welfare.

CES workers reported limited involvement in recent training and educational experiences, while PSU staff indicated a goodly amount of such involvement. None of the workers in either system, however, viewed training as an ongoing and regular process. Training for PSU generalists who handled protective service cases was near non-existent.

The adequacy of staff must also be viewed in terms of caseload levels. CES workers were definitely overworked. Each emergency service intake worker carried an active caseload of approximately forty families. The workers were responsible for resolving crises and long-term case handling which involved cases falling at different points in the protection process.

Workers in the Savannah's Protective Service Unit were not generally responsible for case handling beyond intake and handling the identified emergency or resolving the immediate crisis. On the other hand, generalists who were responsible for child protection cases as well as the usual caseload, were plagued by heavy caseloads. Reportedly, each worker was responsible for forty or fifty cases.

Case Handling: The Service Delivery Process

That a child protective service agency moves toward more severe dispositions as the case progresses would tend to indicate that perhaps interim decisions and/or efforts have been inadequate and/or inappropriate. Adequacy and appropriateness of service efforts aside for the moment, what did the data suggest about the appropriateness of decisions as cases progressed?

Based on the data utilized in the individual case analyses, we determined that case dispositions often appeared to be made without an understanding of client input. Dispositions through time appeared to suggest a lack of indepth assessment of the presenting problems and laxity in case monitoring.

We noted the tendency for CES personnel to move toward more severe dispositions through time in relation to race, seriousness of harm, and age. Observing the trend in disposition by race, we found that a more severe disposition was made in the current incident in approximately three times the percent of cases involving white children than the percent involving black children. In no case was a severe disposition made in both incidents for black children.

We further pursued the above findings in relation to seriousness of harm. Well over fifty percent of the black children were seriously harmed in one or both of the incidents; less than one-third of the white children were so harmed. Of the black children who were seriously harmed the agency made a severe disposition in the current of two incidents in one-third of the cases. This compared to two-thirds of the cases involving white children.

As to age, a more severe disposition in the current incident was made for black children less than three years of age. In one case, the child had been seriously harmed in the first incident but allowed to remain in the home with services. A second case involved serious physical harm in both incidents which occurred within a period of six months. Following the first incident, the child had been allowed to remain in the home with services.

For white children, a more severe disposition was made in the current of two incidents for the old and young alike and for the seriously and not seriously harmed as well. Evidently, other factors than logic are involved.

In the PSU system, the tendency toward more severe dispositions was less pronounced than in the CES system. In general, we found that the movement in the direction of severe dispositions was influenced by the seriousness of harm incurred and/or length of time between the reported incidents.

Comparison of CES and PSU Caseworker Responses to Case Vignettes.--Having made a disposition, a service plan

should become operative. Data from the actual cases as well as that from a set of vignettes suggest that service delivery followed no service plan which speaks to some of the most obvious needs of children and families. As we have noted in a previous chapter the actual services delivered, we will at this point discuss only aspects of service delivery as noted in the vignettes.

Caseworkers were presented eleven detailed vignettes which contained the basic familial, personality, and socio-economic factors of actual cases. Each worker was requested to:

1) Assess the nature of the case, i.e., determine the validity of the existence of abuse and/or neglect;

2) Render a disposition on the case; and

3) Indicate the services which they would render to the child and the family.

A discussion of the workers' responses to a selection of the vignettes follows.

Case 1. A 22 year old mother of four children ages five and under, who remarried after her first husband died, reportedly cursed and beat the oldest and the only child by her deceased husband on every provocation. On this occasion, the child was beaten by his mother with a belt according to the child's aunt. The child suffered from bruises, abrasions, contusions, and cuts. Injuries were considered serious. Sources indicated the child reminded the mother of his deceased father whom she hated. Both admitted the mother sometimes whipped the boy for misbehaving.

All five of the CES caseworkers and four of the PSU determined that the case constituted abuse to the child. One PSU caseworker suspected abuse. There was general agreement among CES workers that the child should be allowed to remain home with services; only one worker recommended emergency removal of the child and a petition for removal for a period of less than one year.

All of the workers in the PSU who made a determination of abuse recommended that the child be removed on an emergency basis; in addition, two workers recommended a petition be filed for removal for a period of less than a year. The worker suspecting abuse recommended the child remain in his own home with services.

Of the thirty-three service choices provided, there was general agreement by four or more CES workers on the provision of physical and mental services for the child, mental services for the parent(s), family planning counseling, and counseling directed toward the parent's unresolved conflicts. Three workers saw the need to provide counseling on parent-child interaction patterns and to provide homemaker services. Four workers indicated home visitation on a weekly basis. Three of these indicated the visits would be unscheduled.

Only two services--referral of parent(s) for mental services and counseling around parental role--were considered necessary in this case by at least four of the PSU workers. Three workers were in agreement on the need for mental and physical services for the child and counseling directed toward parent-parent-child interaction problems. Two workers indicated they would visit the home bi-weekly and one on a weekly basis. The visits would be convenient to the client and the worker.

This 22 year old mother of four children, all under six years of age, represents a protective service case in which some specific services were drastically needed; yet were not considered. None of the caseworkers in either system indicated they would provide cultural-recreational opportunities for this mother. Only two of the CES workers and none of the PSU indicated day care services. Beyond this, none of the PSU workers provided family planning counseling. It is my opinion that the failure to provide these basic kinds of services coupled with the apparent lack of intensive family-agency contact--through lay therapists or more frequent home visitations--would render this case an eventual failure.

Case 3. A 13 year old girl, who had begun to engage in promiscuous sexual activities and taken up the habit of smoking since a serious heart operation earlier in the year, came to the attention of the protective service agency on a referral from a private physician whose services had been sought by the child's mother for injuries resulting from a beating given by the father for smoking. The child had several bruises, abrasions, wounds, and lacerations. The parents, both college graduates with the father being a white collar employee, had three younger children on whom they indicated they never had to apply physical punishment. Since the child's

operation, the father had had to whip her on several occasions for her defiant behavior.

There was unanimous agreement among the workers in both systems that the child had been abused by her father. Three workers in each system indicated that the child would remain home with services. One PSU and one CES worker indicated emergency removal with the PSU worker indicating a petition for removal for a period of less than one year and the CES worker indicating a petition for more than one year. One PSU worker's decision was to petition for permanent removal of the child. One CES worker's decision was to petition for temporary removal for a period of less than one year.

The workers in both systems generally agreed on the provision of casework counseling on child development, needs, and problems; counseling on discipline; mental services for the child; and counseling around parent-child interaction problems. The workers in the PSU indicated that home visitation as part of protective supervision would be conducted at least three times per month. Two CES workers indicated bi-monthly visits to the home and one indicated weekly visits. Workers in both systems indicated that the time of the visits would be suited to the convenience of the parents and the workers.

Of significance in this case was the observation that only one worker–in the PSU system–considered counseling with the child to be a needed service.

Case 8. An eleven month old male child was found to have suspicious bruises by a hospital physician. More evident, however, was what the physician referred to as a mental conditioning to withdraw from human contact, cry when held, and exhibit rigidity. Bad emotioning pattern was also reflected in the baby's failure to thrive.

A sister, 3 years older, was developing normally. The mother was in her early 30's, was a college graduate, but did not work outside the home. Due to personality problems and difficult life situations–debts, sickness, a recent move to a new town–she appeared unhappy and felt anger toward the child. The young father, the holder of a master's degree, indicated that his wife was under stress. Both parents, however, denied abuse and neglect of the child.

Three of the PSU caseworkers suspected abuse and neglect; two suspected abuse. All five of the workers determined that the child should remain in the home with services.

CES workers were more inclined toward labeling the case as one of neglect and to make a disposition of removal from the home. Two workers indicated they felt that abuse of the child had occurred but he should remain in the home with services. Two workers suspected abuse with the disposition to remove the child on an emergency basis and petition for temporary removal for less than one year. One worker suspected neglect and allowed the child to remain in the home with services.

Workers in both systems determined that a variety of services should be provided, with general agreement among the workers. The service areas on which three or four workers in both systems agreed were: mental services for the parent(s), counseling on parent's own unresolved conflicts, cultural-recreational opportunities for the parent(s), child or day care services, counseling on child development. Beyond these generally agreed upon services, three PSU workers saw the need for mental services for the child, physical services for the parent and counseling on budgetary matters. Four CES workers agreed upon the need for family planning counseling and counseling on problems in parent-child interaction patterns.

Three workers in both systems responded to the item of home visitation as a part of protective supervision. All three PSU workers indicated visiting the home three or more times monthly with the time of the visit being suited to the convenience of the client and the worker. CES workers leaned toward longer periods of time between unscheduled visits.

Case 10. A 34 year old mother of six children reported that her 49 year old boyfriend, who lived with her and her children, made the entire family leave the house except for the 13 year old daughter who said the man beat her with his belt and forced her to have sexual relations with him. The boyfriend was known to have whipped all the children on other occasions. The family survived on public assistance and income from the boyfriend's part-time work.

Three of the PSU caseworkers suspected abuse, two of them also indicated suspected neglect. All three of the workers made the decision to allow the child to remain in the home with services. Two workers made a determination of abuse in the case; one worker's disposition was to allow the child to remain in the home with services while the other

make the decision to remove all the children on an emergency basis and to petition the court for their permanent removal from the home.

All of the CES caseworkers made a determination of abuse. Three workers indicated that the child would be allowed to remain in the home with services, while two recommended emergency removal of the child and a petition for temporary removal of less than one year.

Even though four of the PSU and three of the CES caseworkers indicated the child would remain in the home with services, there was little agreement among the workers in regard to the service needs of the family. Three or more of the PSU workers saw the need for physical services for the child, cultural-recreational opportunities for the child, and counseling on child development. Only one worker indicated a need for day care, mental referral for parent (boyfriend), or counseling with the child. Two workers agreed upon the need for family planning counseling.

In terms of services to be rendered by CES caseworkers, four or more workers agreed on the provision of only three types of services–mental and physical services to the child and referral for legal services for the parent(s). Three workers indicated the need for referring the parent(s) for mental services; counseling on the development, needs, and problems of children; on budgetary matters, home management and family planning.

Only one worker saw the need for cultural-recreational needs for the child and parent; two indicated that child or day care was needed.

As to home visitation as a part of protective supervision, the majority of the workers in both systems indicated that visits would be made two or more times monthly.

Commentary on Caseworker Responses to Case Vignettes.–Relevant tabular information regarding worker assessment and determination of services needed in all of the eleven vignettes are presented in Tables 6-6 and 6-7.

Noting Table 6-6 one observes several obvious differences between workers within each system and between the systems in regard to determination on the nature of the case and the dispositions made in relation to the determinations. There was a tendency for PSU workers to be less apt to express absolute certainty on the existence of abuse or neglect. In only two cases did one or more CES workers indicate that the case represented a suspected reportable condition.

PSU workers were more apt to indicate longer periods of absence out of the home when the decision was made to file a petition on the child. It is of utmost importance at this point to emphasize that services were not generally provided to parents during the period of out-of-home placement of children in either system.

Leaving these points aside for the moment, the service needs of children and their families are noted in Table 6-7. Again, one finds wide differences in the assessment of service needs. The greatest agreement on service needs between workers within each system and between the systems was in the areas of mental services for the parent(s) and counseling on child development, needs, and problems. For PSU workers, common agreement centered on the physical needs of the child. CES workers were in general agreement on the need for counseling around parent's unresolved conflicts, family planning, and interactional problems between parent(s) and children.

What the findings in these tables tend to indicate is the need for better guides and more training centered on the dispositional, the case assessment, and service delivery processes.

Implications for Service Delivery

The kinds of data generated from this study, coupled with existing knowledge, suggest that there are several strategic procedural points at which, under present conditions in most community systems for child protection, failure in the child protection process is imminent:

1) the entry stage, including identification, reporting, and investigation;

2) the dispositional stage, which is an element at every other stage; and

3) the case handling/management-treatment stage, including evaluation and service delivery.[1]

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[1] Saad Z. Nagi, *Child Maltreatment in the United States: A Cry for Help and Organizational Response* (Columbus, Ohio: Ohio State University, 1976), prepared for Children's Bureau, DHEW, Washington, D.C.

TABLE 6-6

Case Disposition Agreement

Nashville (CPS)	Workers	Case	Workers	Savannah (PSU)
Abuse - Remain home with services	4	1	2	Abuse - Emergency/petition < 1 yr.
Abuse - Emergency/ petition < 1 yr.	1		2	Abuse - Emergency/petition > 1 yr.
			1	Suspected Abuse - Remain home with services
Abuse - Remain home with services	2	2	1	Abuse - Emergency/petition > 1 yr.
Suspected Abuse - Remain home with services	1		1	Abuse - Emergency/petition permanent
Abuse - Emergency/ petition > 1 yr.	2		1	Suspected Abuse - Remain home with services
			1	Suspected Abuse - Emergency/ petition, petition permanent (also petition other children)
			1	Neglect - Child remain home with services
Abuse - Remain home with services	3	3	3	Abuse - Remain home with services
Abuse - Emergency/ petition > 1 yr.	1		1	Abuse - Emergency/petition < 1 yr.
Abuse - Petition < 1 yr.	1		1	Abuse - Petition permanent
Abuse - Emergency/petition > 1 yr.	4	4	1	Abuse - Emergency removal
			1	Abuse - Petition < 1 yr.
Abuse - Petition < 1 yr.	1		1	Abuse - Emergency/petition > 1 yr.
			1	Suspected Abuse - Emergency/ petition permanent
			1	Suspected Abuse - Emergency/ petition < 1 yr.
Neglect - Emergency child-children/petition < 1 yr.	2	5	1	Neglect - Emergency removal
			1	Neglect - Emergency child-children/petition < 1 yr.
Neglect - Emergency child-children/petition > 1 yr.	1		1	Neglect - Emergency child-children/petition > 1 yr.
Neglect - Emergency child/ petition < 1 yr.	1		2	Neglect - Emergency/petition permanent
Neglect - Remain home with services	1			
Abuse - Emergency child-children/petition > 1 yr. (also petition other children)	3	6	2	Abuse - Emergency/petition permanent
			1	Abuse - Emergency child-children permanent petition
Abuse - Emergency child/ petition permanent	1		1	Abuse - Emergency child/ petition permanent (also petition other children)
Abuse - Petition child > 1 yr. (petition other children)	1		1	Suspected Abuse/Neglect - Emergency child-children/ petition child-children
Abuse - Emergency/petition < 1 yr.	2	7	1	Abuse - Emergency/petition permanent
Abuse - Remain home with services	1		1	Abuse - Remain home with services
Abuse - Emergency/petition > 1 yr.	1		1	Abuse - Emergency child-children
Abuse - Petition > 1 yr.	1		1	Abuse - Emergency/petition > 1 yr.
			1	Abuse - Emergency/petition < 1 yr.
Abuse - Remain home with services	2	8	3	Suspected Abuse/Neglect - Remain home with services
Suspected Abuse - Emergency/petition < 1 yr.	2		2	Suspected Abuse - Remain home with services
Suspected Neglect - Remain home with services	1			
Abuse - Emergency/petition < 1 yr.	4	9	3	Abuse - Emergency removal
Abuse - Emergency removal only	1		1	Abuse - Emergency/petition < 1 yr.
			1	Suspected Abuse/Neglect - Emergency/petition > 1 yr.
Abuse - Remain home with services	3	10	2	Suspected Abuse - Remain home with services
Abuse - Emergency/petition < 1 yr.	2		1	Suspected Abuse/Neglect - Remain home with services
			1	Abuse - Remain home with services
			1	Abuse - Emergency child-children petition permanent (also petition other children)
Abuse - Emergency/petition < 1 yr.	4	11	2	Abuse - Emergency removal
Abuse - Emergency/petition > 1 yr.	1		1	Suspected Abuse/Neglect - Remain home with services
			1	Suspected Abuse - Emergency child-children/petition permanent removal of child

TABLE 6-7

Inclination of Workers Toward Specific Services

NASHVILLE (CFS) Case											Services	SAVANNAH (PSU) Case										
1	2	3	4	5	6	7	8	9	10	11		1	2	3	4	5	6	7	8	9	10	11
5	4	4		3	5	1	2		5	1	1. Mental Referral-child	3	4	3	1	2	5	1	3	1	2	3
4	4	1	1	4	4	2	1	1	4	1	2. Physical Referral-child	3	5	3	4	5	5	4	4	5	4	3
1									1		3. Legal Referral-child	1	2		1	2	2	2		1	1	1
4	4	3	5	4	5	4	4	5	3	4	4. Mental Referral-parent	4	5	2	4	5	5	5	4	5	1	2
	3		4	1	1			1	1	1	5. Physical Referral-parent	1	2		3	4	3	1	3	1		
			2	1	1	2		2	4	2	6. Legal Referral-parent	1				2	2			2	2	2
				4					1		7. Collection and/or repair-material goods (including housing assistance)					3						
1				1		1	1	1	1	1	8. Transportation/professional services	1	1			2	2	1			1	
				1	1				1		9. Cultural-recreational opportunities/child	1	3	1		2	3	2		1	3	1
				4	3	3	4	2	1	1	10. Cultural-recreational opportunities/parent		2				1		4	1	2	1
							1				11. Tutoring or educational improvement assistance											
				3	1						12. Instruction in food preparation/good grooming					1		1				
				2			1		2		13. Transportation/personal needs							1	1		1	
2				1		4	3		2	2	14. Child-day care					1		2			1	
											15. Supervision-parent absent	1	1		1	1		1		1		
4	5	3	5	4	4	5	3	4	3	4	16. Child development-needs problems	2	4	4	5	4	4	4	4	5	4	3

TABLE 6-7 (cont.)

NASHVILLE (CES)

Case										
1	2	3	4	5	6	7	8	9	10	11
1	2	4	1		5	3	1	1	2	2
	1		2	4		4	1	3	1	2
				5			2		3	2
3	2	3	3	3	3	3	3	4	1	3
4			4	4	4	3	4	4	3	4
				5			2		3	
1	2	4	3	1	4	4	3	3	1	3
4	4	4	5	4	4	4	5	4	1	5

SAVANNAH (PSU)

Services	Case										
	1	2	3	4	5	6	7	8	9	10	11
17. Counseling-discipline	2	2	4	1	1	2	4	1	1	2	2
18. Marital problems			1	1	3		4	1	1		
19. Budgeting					1			3		1	
20. Parent-child interaction	2		4	1		1	1	2	2	1	
21. Family planning		3	2	2	3	4	3	1	2	2	1
22. Home Management					1					2	
23. Parent-parent-child interaction	3		2	2	1	1	1	1	1	1	1
24. Parent unresolved conflicts	2		1	4	2		1	3	4		4

That failures in the child protection system occurs at each strategic point is no question. There is no question that approximately sixty percent of the reported children have been previously abused. There is no question that the current incident in a series of incidents has a relatively high probability of being more serious in nature than previous incidents. There is no question that efforts to rehabilitate parents and prevent further abuse and/or neglect have generally failed. What appears to be of question, is what is to be done to minimize present failures in the delivery system.

For protective service systems to fulfill their mandated responsibility each suspected case must be conscientiously handled from start to finish, i.e., from the receipt of the report or complaint (input) to the investigation, to emergency action and court proceedings, if warranted, and to the strengthening of the family, if possible, through support services. In order for this mandated responsibility to become a reality, a network of community interactions beyond the boundaries of single systems must be coordinated.

The above description gives a generalized picture of a working protective service system. What is missing, however, is an explicit statement of the process in the "from start to finish," the agency organization for moving the process, and the community's responsibility in the process.

Case Handling Process.–Undoubtedly, most child protective service (CPS) workers would assert that a specific process is adhered to in handling and providing services to abused and neglected children and their families. And while we will not argue that point, data from the present study suggest that the process, if one exists, needs to be more clearly specified and/or existing problems prevent the realization of the procedural plan.

The data revealed process problems which were common to both systems studied as well as problems unique to each system.

In the CES system, the following recounted problems suggest the need for a better processing of protective service cases:

1. A large percent of the cases were apparently not carried to its logical conclusion; namely, from entry through the major dispositional points, through thorough diagnostic evaluation, planning, service delivery, re-evaluation, etc. We noted in the total caseload, that a recommendation for a petition for temporary removal was made in approximately forty percent of the cases for which there were no prior reported incidents and in a slightly higher percent of those for which prior reports existed. This finding was borne out in the cases which were subjected to individual case analysis.

   In relation to the above tendency in the agency's dispositional stance, we noted that seriousness of harm suffered by the children was not a major factor in the decision-making process.

   Beyond this, while a petition was recommended and subsequently filed in a high percent of the cases, subsequent court actions suggest that the process through which a large portion of the cases had passed was either aborted or not well executed. The court returned a relatively high percent of the children involved to one or both parents. Additionally, a relatively low percent of the children were placed in foster care.

2. The response set in the investigation process was not as discriminating as this dispositional point warrants. As indicated earlier, the degree to which CES personnel could actually set priorities to investigations was hampered by the fact that they were responsible for investigating practically all complaints, while carrying an on-going caseload of approximately forty families. Obviously, time spent on non-serious complaints detracted from the time available for situations warranting immediate intervention.

3. There was a high recidivism rate. Among the cases subjected to individual case analysis we noted further that re-entry into the system occurred in a short period of time in a high percent of the cases.

   In a high percent of the two-report cases (individual cases analysis), the children were seriously harmed in both incidents or in the more current of the two.

   There was a general tendency for the agency to move toward more "severe" dispositions as

cases progressed in terms of reported incidents.

These findings would suggest failures in the child protection process at one or all of three crucial points: (1) the diagnostic stage, (2) the planning stage, and/or (3) the service delivery stage.

The problems in the PSU system which suggest the need for a better processing of child protection cases were substantially different from those observed in the CES system.

1. Some of the children reported to the PSU system failed to gain entry from the outset. Reportedly, some cases, even though they may have well been the proper domain of the protective service unit, were simply not investigated.

2. There was no way of assuring the flow in the protective service process. Active cases, previously referred cases, and/or cases not of an emergency nature were referred outside the PSU for investigatory purposes. Such cases were not documented in the Unit's log. There are obviously pluses and minuses in such an operation of deflecting non-crisis cases from the protective service unit. On the plus side, the CPS worker can better manage its time in terms of crisis intervention. On the minus side, particularly in the absence of documentation of such cases, the Unit chances by-passing cases which are in fact serious in nature.

   Beyond this, generalists, who received little or no training in protective service delivery, were responsible for investigating such cases. In this instance, they were responsible for decisions which rightfully belonged with those identified as specialists.

   In addition, such personnel were responsible for on-going case handling processes for the cases they investigated as well as those investigated by the protective service unit (PSU).

3. The lack of 24-hour intake posed problems for the orderly sequencing of the service process. For example, case assessment by the PSU might well have occurred after parents were jailed and children were unnecessarily and inappropriately removed from the home. Other factors which contributed to the problem included the lack of emergency services which could be brought to bear in emergency intervention, and the lack of coordinated efforts with community collateral systems.

4. In a relatively high percent of the two-report cases, the children were seriously harmed in both incidents or in the more current of the two. While less than in the CES system, PSU personnel moved toward more "severe" dispositions as cases progressed in terms of reported incidents.

   These findings suggest failures in the child protection process at one or more of the crucial points.

Factors common to both systems which indicate a need for a closer look at the total service delivery process were:

1. The failure to rehabilitate perpetrators--in both systems, an overwhelming majority of the cases involved the same perpetrator in all of the incidents involving a given child;

2. In neither system were their consistent and intensive efforts to work with parents of children in placement; and

3. In neither system did case handling involve overseeing and coordinating the services and activities of other agencies to the children and families.

Indeed, one wonders about the extent of planning and overseeing of the internally rendered services.

Organizational Model.--Some of the observed problems, which increased the probability of failures in the handling (process) of protective service cases, also gave rise to the need for a closer look at the organizational model through which the process flows. A more detailed discussion in this regard will be addressed in a subsequent section.

Community Responsibility.--Child protection has traditionally been viewed by the public (community) strictly as

the public social service agency problem. Sadly enough, agencies have reinforced such views.

This is not as it should be. The thinking must change. What comes to mind is community involvement in other facets of community life. For example, a community is given the opportunity to decide, through its voting power, whether or not it will allow the selling of mixed drinks on Sunday or whether or not it will finance a new transit system, a new superdome, etc. The success or failure of the "owned" enterprise becomes a community responsibility.

Similarly, the welfare of children is a community affair. Child protection is a community enterprise. While one agency, by necessity, is mandated to receive reports of maltreatment to children and to oversee the child protection process, no one agency singularly should nor can realistically bear the weight of the responsibility on its shoulders.

Let us at this point, emphasize some existing knowledge and some findings from the present study which warrant our taking the position of coordinated community involvement in child protection.

1. The community is involved in the process from the very start through the provision of input into the system via reports of known or suspected abuse and neglect. Without such involvement, the total community would have failed its children by mere inaction.

2. The community, directly and indirectly, pays the price for failures to children. There is increasing concern and a growing body of knowledge which suggest that abuse and neglect may be related to juvenile delinquency and to adult deviant and criminal behaviors. The costs involved in tracking down run-aways, curing alcoholics and addicts, building facilities and providing services for delinquents and criminals, etc. are charged indirectly to the public. Direct costs the public incurs stem from acts of the addict, the delinquent, and the criminal against their person and/or property. Thus, the community must claim a stake in the problem.

3. The protective service agency can be little more than the public pays for. Agency personnel--service providers--are usually inadequately prepared through prior education and experience. They carry unmanageable caseloads and they are provided little training. The point is to emphasize only that in the average protective service worker the community has not paid for a single specialist, let alone a variety of specialists which many protective service cases require.

   On the other hand, the community represents a wide variety of publicly financed specialized skills which can and should be brought to bear at crucial stages in the protection process.

4. The majority of the services and resources available to the agency reside in the community.

5. A vast number of the children and families known to the protective service agency are served by one or more additional community agencies. What is sorely lacking is a coordination of service efforts.

Given the above, it is difficult to see the problem of child abuse and neglect as anything other than a community-wide problem for resolution. It appears improbable, however, that community "ownership" of the problem occurs without:

1. The community, via its representatives, having input at crucial dispositional stages when such is warranted, and

2. The community becoming an integral part--a partner--of the service plan.

A Proposed Plan for Improving Service Delivery

In this section we will consider a model for the delivery of protective services and an organizational model through which the process can occur. Beyond this, some recommendations are offered for training needs.

Proposed Process Model for the Delivery of Protective Services

Figure 6-1 represents a proposed process model for handling/managing protective service cases. According to this model there are seven steps in the case management process:

1. intake,
2. investigation,

3. diagnosis/indepth evaluation,
4. case planning,
5. service arrangement and provision,
6. overseeing, and
7. recording.[2]

As the major purpose of each of the steps included in the model is generally understood and accepted, the focus of the ensuing discussion will be centered primarily on the process and components involved in each step and a general commentary on the importance of each step in the total process. Content matter involved in each step is generally not dealt with simply because our data did not speak to such issues. As such, the following discussion *is not* designed to be a "how-to-guide." The major purpose is to emphasize the processes involved and some consequences of aborting the processes involved in the steps.

Intake.--The intake procedures involves two major processes--intake and the intake study--both involving a critical decision point.

Intake is a fact-finding process through which a decision is made regarding the appropriateness of the case as one which falls within the scope of the protective service agency's function.

The initial intake involves (1) gathering information and (2) assessing the information.

We have generally viewed this initial fact-gathering process as one in which minimal evidentiary data are obtained relating to the condition of the child, identifying data on the family, identity of the reporter, and the reporter's evaluation of the nature and perceived seriousness of the alleged condition of the child.

As two major decisions rest on the assessment of the facts gathered in this initial process--the appropriateness of the case for agency action and the appropriate response following the acceptance of the case for agency action--it appears that of equal importance to that of the minimal identifying data to be obtained is the need to obtain, if possible, some indication of the volatileness of the situation. The worker might be able to determine, among other things:

1. Whether or not the reported incident is an isolated observed incident or an on-going occurring situation;

2. If the family has experienced any recent major changes, e.g., death of an immediate family member, remarriage of a parent, etc.; and

3. The emotional investment the reporter has in the incident(s).

A report made in person undoubtedly provides the best opportunity for the intake worker to gather the kinds of facts needed to make an indepth intake study. It is suggested that any self-referral be given careful consideration with emphasis being as much on the presentments of the reporter as on the conditions of the child.

Armed with the facts gathered in initial intake, the worker makes a decision on the appropriateness of the case in regard to the agency's functions. To accomplish this, the worker must go a step beyond gathering information. The facts must be weighed; a determination regarding the meaning of the information must be made. The assessment of facts toward problem definition is the second process involved in intake.

Having assessed the facts, the worker makes a determination on the case. If the case cannot be deflected from the protective service unit through information and/or referral, it properly becomes a case for agency action.

If doubts persists the worker should not hesitate to make every attempt to confirm or dispel these doubts. Any remaining doubts must be resolved in the favor of the complaint. A field investigation to explore the situation is warranted.

Should cases, which are the proper domain for the protective service agency, not be referred to and/or not be accepted for agency actions and services, there is the possibility, however, remote, that the children may well be in present danger and/or may subsequently receive serious harm. I am particularly reminded of an article which reported on a case

[2] It is of significance to note here that other RISWR staff had independently developed a case management process model for protective services which speaks to the issues and needs highlighted by failures revealed by the data in the present study. The current model, therefore, represents a collaborative RISWR effort. The details and requirements of the model are described in an Institute publication: D. G. Boserup and G. V. Gouge, *Case Management for Children's Protective Services.*

involving a self-report of a young mother to a community health center in New Jersey. She brought in her severely burned child whom she explained had been accidentally burned on a radiator. While the mother appeared troubled, the explanation appeared to be a logical one to the worker who talked (counseled) at length with the young woman. Rather than reporting the case, the worker suggested to the young mother that she could always return to the center when she felt the need to talk. The young mother never returned. Two weeks later the child was D.O.A. at a local hospital from cuts and stab wounds.[3]

The irony of the above account is the fact that the young worker had recently taken part in an intensive training program focused on identification, reporting responsibility, and dealing with individual attitudes and values.

How many inadequately prepared protective service workers have even less training? How many protective service workers fail to obtain as much information as feasibly possible upon which to make two of the most important decisions in the child protection process; namely, is this a proper case for the agency and, if so, what actions are indicated?

Agency action is based on a detailed *intake study*. Does the information suggest expediency or can routine procedures be followed?

The intake study warrants (1) an analysis (sorting out) of the information gathered in the initial intake process, and (2) consultation with supervisory personnel.

It would appear, and the data suggest, that a high level of discrimination is needed in screening out cases demanding emergency action from those which can be handled in a routine manner. Without discrimination, problems may well arise such that many non-serious cases are investigated in short order while some serious ones must be delayed for investigation.

The analysis must take under consideration the alleged condition of the child, the nature of the maltreatment, the perceived familial circumstances which could be considered risk factors, and the emotional tone of the reporter. In considering all of these factors, the worker should be mindful of the child's age and personal problems, if such data were obtained.

In making a determination on the expediency of agency action, perhaps a response pattern should be instituted setting priorities on broadly defined situations involving specific kinds and degrees of maltreatment by age specifications.*

While the data are inconclusive, the following general prioritized response pattern seems to be advisable:

1. Situations of present danger, in which physical or sexual abuse to infants and young children might be involved; or which are characteristized by lack of supervision, abandonment of infants or young children, or serious physical abuse of older children.

2. Situations of imminent danger involving such indicated maltreatment to older children.

3. Situations having highly probable negative long-range consequences to children–neglect conditions.

The problem with any pattern is the tendency toward routinization. Thus, any pattern accepted for action must be flexible. Not all physical abuse to young children present danger; however, the probability of physical abuse being of a serious nature is significantly higher among infants and young children than among older children.

Having analyzed the information gathered in intake and having made some initial decision regarding agency action, it is encumbered upon the worker to consult/confer with a supervisor regarding the information and the analysis of it. The decision regarding the nature of immediate agency action should rest primarily at the supervisory level.

Should the decision for crisis intervention be made, coordinated investigatory procedures with the juvenile court intake might prove beneficial. Such procedures worked well

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[3] "Report on a Failure" in *P.S.R.I. Report*, Vol. 1, No. 2 (June, 1976). Published by the Protective Services Resource Institute, Rutgers Medical School, Piscataway, N.J.

*CES project personnel indicated general types of situations which were categorically earmarked for immediate intervention. See Johnson, *Two Community Protective Service Systems*, p. 21. We noted, however, that the screening process resulted in a somewhat indiscriminate response pattern.

in the CPS system. The cooperative field assessment reportedly resulted in joint decisions regarding the emergency needs of children and their families.

Investigation.--Investigation in protective services involve field procedures in which the worker is faced with making decisions on the validity of the report and on the appropriate actions should abuse and/or neglect be confirmed.

Toward making a determination of the validity of the report, the worker's investigation logically involves:

1. contacting the family;
2. observing the child and other children;
3. where the need exists, contacting persons other than the family for the purpose of gathering additional information; and
4. assessing the information.

Prior to contacting the family if the nature of the situation allows the time, the worker should study the information gathered in the intake process and consult, if possible, the Social Service Exchange.

The first contact with the family may be a trying situation for the worker. Whether the client is hostile in view of what is considered agency invasion of privacy or whether they are cooperative, the worker's responsibility is to interpret the agency's function and its obligation to explore the reported complaint. Needless to say, highly trained persons are required to undertake the tasks of gaining entry into the home, initiating and maintaining an objective relationship during the initial interview, and obtaining information regarding the complaint.

If the worker gains entry into the home and establishes the reason for the agency's intervention, the worker should request to see the child and other children in the family.

The failure to gain entry and/or to observe the child cannot be signals to close the case. Rather one or both of these occurrences and the need for additional information, in view of accounts conflicting with that of the reported complaint and/or general lack of cooperation, should sensitize the worker to the need to contact persons other than the family. If possible, however, such contacts should not be made without the parent's knowledge.

The information gathered by the worker in the field investigation, which may involve several visits, must be assessed at two major points; namely, at the point of determining immediate actions and at the point of indepth evaluation. Obviously, in emergency situations, the worker must make an immediate assessment in order to take actions to prevent further harm to the children. One possibility in such situations involves the worker calling in for police assistance. Another possibility, to which we alluded earlier, might involve a coordinated and conjoint investigation with juvenile court/police intake in alleged serious situations.*

If the complaint is confirmed the worker should apprise the parent of the initial assessment of the facts uncovered. By the same token, the worker needs to withdraw from the situation as tactfully as possible in such a manner as to leave the parent(s) with the least possible resentment against him/her and the agency when complaints of abuse and/or neglect are disproved or by definition do not warrant further action.

It is necessary to investigate, on a priority basis, all reported complaints as expediently as possible. Expediency is especially necessitated in cases involving reports of physical beatings. Unlike signs of on-going neglect, signs of physical abuse become less visible with the passage of time and in many cases of physical abuse, particularly in regard to very young children, visible signs are the only evidence on which intervention can be justified.

Where or to whom do protective service workers report when doubts persist but evidence is not attainable? I am reminded of a case in which immediate entry into the home and observation of the child simply did not occur. The investigation process was aborted to the eventual detriment of the child and perhaps the family.

Coordinated and conjoint intake/investigative procedures with the juvenile court or law enforcement would appear to be of benefit in such situations. Unlike most protective service agencies, police forces operate on a 24-hour basis. The actual case emphasizing the aborted investigation process follows.

Earliest Report: Child was age 2. Extent of injuries was undetermined. Report indicated child flung to the floor by stepfather. Parents

*Situations in which removal of the child and/or other children is effected should be purely of an emergency/crisis nature.

evaded worker who, after not being able to make contact immediately, made the disposition to allow the child to remain in the home with services. A worker's documentation indicated "...Parents not receptive to any kind of services or assistance with problems, I do not see that the agency has any right to intervene further."

Case closed after three months.

Second Report: (1 year later) Serious beating by stepfather. Child was removed on an emergency basis and a petition was filed. Child was in foster care one month. As a new baby was born during this time, a homemaker was provided. No other *service provisions were documented*.

Parents and agency obtained legal representation. Stepfather was indicted by the County Grand Jury.

Third Report: (6 months later) Serious beating by stepfather, state of neglect, failure to thrive. Stepfather not yet tried. No petition. No documentation of services.

Diagnosis/Indepth Evaluation.–Following as thorough an investigation as possible, the next logical step in the child protection process is that of diagnosing the facts. This step is warranted in any instance except those in which the complaint was determined to be unfounded and/or invalid. This prescription would apply to cases involving immediate placement of children as well as those involving no more than admonitions or "counseling" around the problem during some period of the investigation process.*

This step involves a heavy reliance upon information gathered in the investigation. The facts must be sorted out, evaluated, and studied toward the goal of problem definition and subsequent planning and action.

The sorting out process should involve laying out the information by specific problem areas, among which are the nature of the maltreatment, child's problems beyond those related to the abuse and/or neglect, observable parental problems, and environmental factors including interpersonal familial relationships.

The sorting out process should make for a more defined process of examining and evaluating what the information means when it is taken as parts of the total picture. The two-fold purpose in evaluation is to determine if the reported condition is, in fact, a valid case for continued agency action, and to make some determination regarding possible causes.

Undergirding the explicit purposes are the implied need for evaluating the family situation in terms of future danger to the child and making careful evaluation of the strengths as well as weaknesses in the family.

The information needs to be studied in terms of what it all means for the child, the parents, future agency involvement, and the direction initial planning can take.

It is particularly important at this stage in the child protection process that the agency involves expertise of the various specialists in the wider community. Physicians, child development specialists, marriage and family counselors, psychologists and other professionals may be pulled together as a consultant team to aid the decision making process on an as-needed basis on difficult and serious cases.

Seemingly, there are two major advantages in involving a group of outside professionals in the diagnostic evaluation step. First, it offers the child protection agency an opportunity to avail itself of services which it normally does not have at this important juncture of case handling. Equally important, it moves the ownership of the problems of child abuse and neglect more toward a community enterprise.

The involvement of such a team in a given case would normally be on a one-time basis. However, if as the case progresses and unusual circumstances and/or information bearing on the case are revealed, further involvement of the team might be indicated. Beyond this, agency personnel (CPS caseworker) needs to be involved in continual re-evaluation as the case progresses.

Case Planning.–The purpose of planning is to develop and maintain a case plan. It is in this step that parent/client

*More careful consideration, however, must be given to the entire process and nature of intervention. One point the data from this study clearly indicated and that is the tendency for the agency to become involved and remain "involved" for less than probable cause. Beyond this, involvement often fails to be meaningful.

involvement should become an integral factor in the child protection process.

The direction case planning takes depends primarily upon the identified problem(s) and the availability of resources which can be brought to bear on the problem needs.

Basically, this step involves:

1. A re-assessment of the problem area(s) toward definitive problem statements,

2. Assistance to the parent(s) to gain awareness of the perceived problem(s),

3. Identification of service needs, and

4. The setting of short and long range objectives for arranging, providing, and overseeing service.

In re-assessing the problems revealed in the indepth evaluation, it is essential that the worker assists the parent(s) in understanding the causes of the abuse and neglect. These are important processes inasmuch as the abusing and/or neglecting parent either views aspects of the child's behavior as the cause of the maltreatment or does not generally relate the maltreatment to parental problems.

Identified services should be directly related to identified problem areas. Services should not become a part of the case plan simply because they are available. By the same token, the worker should exhaust every effort to locate needed services which are in small supply. It stands to reason that if services are not appropriate to the needs the planning and subsequent case plan have little meaning.

In regard to the identification of service needs, efforts should be made to determine from the parent/parent substitute their present involvement, if any, with other service agencies. It is through this process that additional service needs can be identified and duplication can be avoided. Beyond this, a more coordinated plan can be developed resulting in less fragmentation of services and less confusion for the parent/parent substitute.

The goal setting process sets the parameters of the case plan: What problems are resolvable in short order against those which can be deferred? What is the absorption capacity for given services in terms of the agency and community resources? Who will be responsible for addressing specific objectives? Are there problems the family can manage? How will progress toward meeting the objectives be determined?

The planning step appears to be an appropriate stage in the child protection process at which the agency might involve the community. Representatives from other agencies presently involved with the family and/or will be involved as a result of the identified needs can assist the agency as a team to work with the family on a long-term basis.

Obviously, such a team would not be needed in some cases. Many cases are served solely by the child protection agency. This would be true of cases involving only casework services and/or protective supervision.

Where the team approach seems appropriate, it might be advisable for the agency to explain the problems to the parent(s), to indicate service needs which result from conjoint efforts, and to gain their acceptance/rejection of team efforts. Such a procedure would appear to lead to more cooperation by and less confusion for the parent(s) in the case planning and service arrangement/provision processes.

Where such teams are utilized they should become an integral part of the treatment process. Obviously, parents should be involved in the team meetings.

Service Arrangement and Provision.–The arrangement for the provision of services involves the worker's designating and establishing parent contact with service providers–intra-agency and inter-agency.

Beyond designating and establishing parent contact with service providers, it is the worker's responsibility to see that the established relationship with service providers is sustained as required by the parents' service objectives.

The activities involved in arrangement, particularly in terms of inter-agency confusion and complexities, would be less problematic if potential service providers are included in the case planning stage as well as in the arrangement and actual provision of services.

Depending on the nature and extent of the family's service needs, the provision of services might be offered by several service providers both internal and external to the agency.

The CPS worker responsible for the case may serve as a

service provider and/or a case manager. While the worker must assume a degree of independence in meeting the service needs of families, the CPS supervisor should share the responsibility at any major decision point.

In the event that the child(ren) is removed from the home, the agency should provide services to the family according to the case plan in anticipation of the return of the child(ren).

Overseeing.–Overseeing is an on-going monitoring and assessment activity in which the major concern is whether the case plan is being implemented according to expectation.

The monitoring process serves as the basis for making a determination regarding the appropriateness of the case plan, the movement toward the stated objectives, and the need for changes in the overall plan, e.g., making decisions regarding case closure, etc.

Part of the case plan should provide for regular in-person contacts. The regularity of contacts will depend on the stage in the protective service process, the needs of the family, the identified risks in the family to the child, and the worker's time and role, e.g., supervisor, service manager/coordinator, and/or service provider. It would appear that if a worker provides casework services including "protective supervision," in-person contacts should occur on a weekly basis. In making decisions regarding regularity of contacts, however, some consideration must be given to the nature of the case–age of child, chronicity of maltreatment, family problems, etc.

On each visit to the home (child in own home or in foster home) the worker should make a point to see the child. And in the casework process, the worker must be ever mindful of the fact that both the parents and the children have problems.

The most logical reason for infrequent home visitations, even when situations seem to indicate frequent monitoring, is probably that of worker's limited time. Perhaps by utilizing a team in the case planning, arrangement, and provision processes, some responsibility for home visitation can be delegated to others among the service providers. As such a team would meet on a scheduled basis specified in the case plan, the service provision and overseeing activities of the several service providers can be assessed and coordinated.

If a team approach is not utilized, it would be necessary for the worker to apprise and otherwise involve the parent/parent substitute in the assessment of the monitoring results. Similarly, other service providers must be contacted on a regular basis for input into the overseeing process and for feedback regarding assessments made and any decisions which effect changes in the case plan.

Recording.–Record keeping is the process of maintaining information which can be utilized for the general purposes of communication and accountability, showing effectiveness of services, and for internal decision-making functions in regard to the case. This is an ongoing activity which is a vital aspect of each of the steps in the case handling/management process.

In contrast to the usual primary purpose attached to recording; namely, management/information and control purpose of reporting, data compiled and kept for the purpose of case handling/management are intended primarily for the purpose of immediate line staff access and use.

As a tool (ideally, standardized and organized) for the service provider(s), case handling/management records should improve client tracking, provide a basis for communications regarding the case, and facilitate supervision and make routine case transfers possible.

Proposed Organizational Model

There are three broad and separable units of functioning in the protective service process:

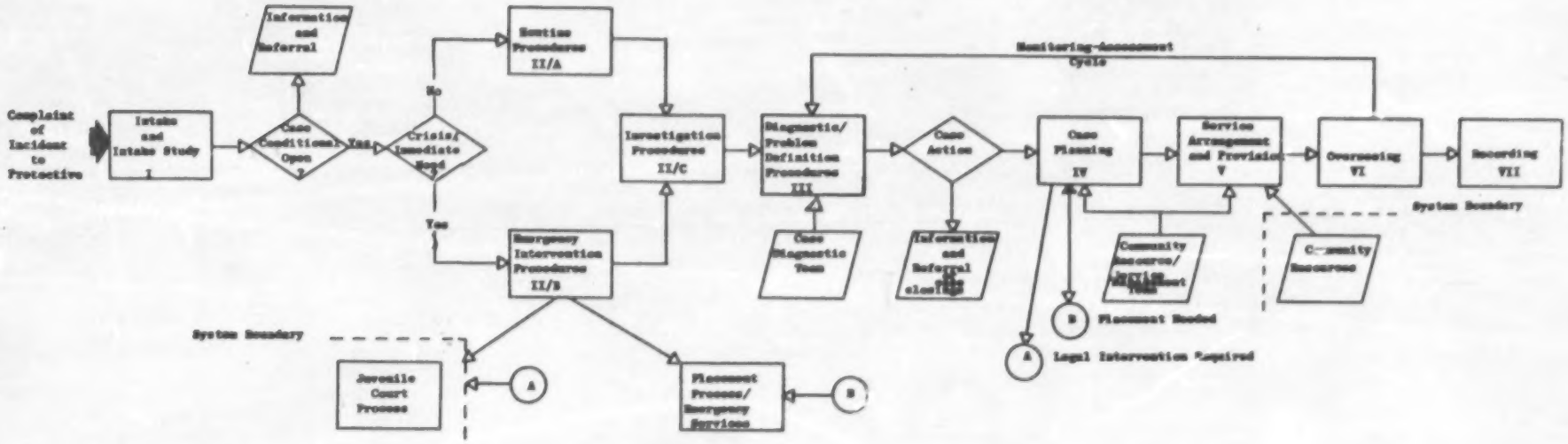
1. intake/investigation,
2. case handling/management-treatment, and
3. placement.

While the focus and activities of each unit are in many ways different from the other, the staff may be the same for each of the units or there may be different staff. The direction an organization takes is undoubtedly influenced by the perceived advantage of one type of organization over another, the degree of specialization sought, the volume of protective service cases, the adequacy of staff, and the type community (urban-rural, inner city, etc.) the agency serves.

Figure 6-2 represents a model which separates the staff by the units of functions. Some consideration of alternatives to this model must be made in terms of the rural versus urban (generic vs. specialized) construction. In rural areas, the

FIGURE 6-1

Case Management Process for Protective Services



worker(s) responsible for child welfare cases may also be responsible for protective service cases. At the same time, such a worker(s) may be responsible for implementing all of the steps in the protective service process.

There is nothing dramatic or new about the present model. Our proposing this model with general functional descriptions, however, has resulted from insights gained from the data, from discussions with personnel and our on-site observations in the two systems, and reliance upon existing knowledge.[4]

At the time of the study, the CES system operated on the basis of one and the same staff being responsible for each of the broad functioning units including services to children in out-of-home care. While the emergency foster care component was responsible for locating foster care placements, the intake caseworker was responsible for "treatment" for the child.

Such a model provides for continuity of care. However, this failure to separate staff in a system (such as the CES in a large metropolitan area which receives a constant inflow of new cases) may result in some steps in the child protection process being neglected.

The data from the present study indicated that the intake and investigation functions in the CES system were realized with a high degree of success in terms of the immediacy of response to complaints. Appropriateness of decisions made in regard to emergency services provided aside, the intake caseworker had access to an array of services which could be provided on a "moments" notice. On the other hand, the case handling/management-treatment functions were severely sacrificed. We have previously noted that the intake caseworkers were hampered by heavy caseloads which involved cases falling at different points in the protection process. Beyond this, the data resulting from the evaluation of effectiveness (based on our developed set of criteria) indicated failures in the "treatment" process.[5]

The delivery of services to children in the Savannah system involved three separate staffs; namely, intake/investigation, case handling/treatment, and placement. While the PSU organization does not differ from that described in our proposed model, specific processes and structural factors limited effectiveness.

The "specialized" protective service unit (PSU) was not hampered by a build up of on-going cases. On the other hand, the Unit had little access to resources which could be brought to bear in emergency situations. Beyond this, the restricted intake hours, coupled with a lack of coordinated efforts with other community intake sources, severely hampered the Unit's functioning. In addition, on-going services to children and families were not provided by staff trained in protective services.

Also by way of introduction, perhaps it is not too presumptious to suggest that each of the above organizational models can realize a degree of success given:

1. Adequate resources;
2. An adequate staff–in terms of preparation and training and worker-client ratio;
3. Intra-and interagency cooperation and coordination; and
4. An awareness and implementation of the steps involved in the processing of protective service cases.

Elements of the Proposed Model.–The proposed model provides for three separate staffs:

1. the intake/investigation staff,
2. the case handling/management-treatment staff, and
3. the placement staff.

While this separation and suggested relationship between the staff may not be feasible nor operational in some systems, insights gained in the present study and the realization of

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[4]For a discussion of the advantages and disadvantages of five basic organizational models, see U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Public Service Administration: *Protective Services for Abused and Neglected Children and Their Families* (SRS) 77-23042, pp. 29-33.

[5]For a discussion of problems in the "treatment" process in the CES system see National Center for Comprehensive Emergency Service to Children *Comprehensive Emergency Services: Community Guide*. Second Edition. (Nashville, Tennessee: Nashville Urban Observatory), pp. 111-112.

the diverse requirements of the separate broad functioning units lead us to suggest its applicability in protective service agencies with a constant inflow of cases and adequate resources and staff.

In proposing this model, it is not without knowledge and understanding of communities in which the protective service network operates out of organizations or settings other than the public social service agency. As the basis for this model rests on insights gained from the study of protective service systems based in the public social service agency, we can only suggest their applicability in similar settings.

Beyond this, agencies must be aware of internal "turf" problems which can arise between separate staff involved in the total protection process. Of particular concern would be the potential for problems between the placement and the treatment staff regarding the supervision of the child.

The intake/investigation staff would be responsible for the processes involved in steps one and two of the child protection process (see Figure 6-1 and the attending discussion). Beyond this, the staff would assume a major responsibility when court action is required.

A separate *case handling/management-treatment* staff would be responsible for the monitoring-assessment cycle which includes the processes involved in steps three through six; namely, diagnosis and problem definition, case planning, service arrangement and provision, and overseeing. *This staff would also provide services to children who are placed in foster family care and their families.*

In the present organizational model, *the placement staff* is separable from yet an integral part of the protection process.* As a separate functioning unit, the placement staff in an agency has the responsibility for handling all aspects of nonprotective child welfare placements. As a part of the protection process, the placement staff would assist the case handling/management-treatment staff--responsible for the monitoring-assessment cycle--by assuming the responsibility for locating foster homes, arranging for placement, cooperating with the caseworker in matters relating to the child during the placement, being responsible for paperwork and agency accountability factors related to foster care services. Given the nature of the proposed relationship between both staffs, it would be necessary for a worker(s) from the placement staff to be involved in the service arrangement and provision step when the case plan provides for foster care placement.

Such placement staff may be called upon by the intake/investigation staff in emergency situations to locate and arrange for emergency short-term placements.

A. Advantages of the Proposed Model

There are several possible advantages of the proposed model:

1. Eliminates a build-up of cases in the intake/investigation unit;

2. Lends itself to a more discriminatory response pattern in intake and investigation;

3. Enhances the probability of intensive and effective case management-treatment services to children and families requiring on-going intervention;

4. Sets the stage for recruiting and training staff around specific needs and skills required for the different functioning areas;* and

5. Provides for continuity and coordination of care to children and families during the assessment-monitoring cycle.

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*Beyond possible conflict between staffs regarding supervision of the child during foster care placement, agencies will also need to consider foster parents if these suggested changes are instituted. Foster parents usually care for children under protective and nonprotective conditions. The suggested changes would require more than one worker in the foster family home even in a protective service case. Would this constitute undue family disruption?

*While training in the area of protective services is presently not provided to meet differential needs, I am personally convinced that while there are areas of common general needs there are training needs specific to the intake/investigation function and to the case handling/management-treatment function. The Institute has recently initiated a research effort involving CPS caseworkers and supervisors in the eight states in Region IV to determine actual and perceived roles and qualifications. One focus of the study is designed to determine if roles and qualifications differ by function in the protection process. The findings should have useful implication for training needs.

B. Requirements of the Proposed Model

A model is a guide, a framework; actual operations may approximate the intent of the model or deviate substantially from it. There are specific requirements which must be met if success as indicated by the specified advantages of the proposed model is to be realized.

Elimination of Caseload Build-up in the Intake/Investigation Unit.--In order that the build-up of on-going cases does not occur in the intake/investigation unit, several requirements must be met:

1. Clearly defined policies and procedures;
2. Intra-agency coordination and cooperation;
3. An operational definition of crisis; and
4. 24-hour intake services.

Defined Policies and Procedures.--In simple terms, policy refers to a program of goals, values, and practices which are designed primarily to regulate and organize a system's processes and the behaviors of participants within and/or between systems.

In relation to the entry stage in the child protection process, policies regarding case definition, case action, and case movement must be clearly stated such that each component staff understands that which is expected.

While policies must allow for some flexibility on the worker's part, they must serve as a firm basis for action. Policies define cases appropriate for agency action; they define the appropriateness of action by the agency; and they define the course of movement cases take within the agency. Beyond this, policy statements should include or be accompanied by specific procedural statements. What are the means to the desired goal as addressed by policy?

Intra-agency Coordination and Cooperation.--Coordinated procedures as set forth in agency policy and cooperation within the framework of the procedures must exist if cases are to move smoothly, efficiently, and expeditiously from the intake/investigation unit to that of case handling/management-treatment.

A clearly defined set of policies and procedures in and of themselves do not guarantee desirable results. The realization of objectives and goals depends upon behaviors of participants in the system.

To ensure the desired behavior, it is essential that top administrative personnel give positive sanction to the program's operation and staff.

The proposed model (Figure 6-2) assigns all intake/investigation responsibility to that staff. Cases handled through routine procedures would be passed on to the case handling/management-treatment staff following investigation procedures. Crisis cases, involving emergency intervention efforts, would be passed to the treatment staff upon resolution of the immediate crisis and the completion of the fact-finding process.*

It is of importance to note that the diagnostic process can be initiated even though the child may be in temporary care. The placement of the child would involve the placement staff.

Operational Definition of Crisis.--The extent to which cases can be resolved and passed on in short order determines the extent to which the intake/investigation staff can prevent a build-up of on-going cases. One factor which could contribute to such a build-up of cases would be the failure of the intake/investigation staff to successfully transfer cases to the treatment unit due to the Unit's failure to comply with policies and procedures. Such a situation we have previously suggested may be remedied in part by continuous positive sanction by top administrative personnel.

An additional factor which can lead to a build-up of on-going cases for the intake/investigation staff is the absence of a clear understanding of what constitutes a crisis. When does a crisis end? And when does the intake/investigation staff terminate its active involvement?

In order to accomplish the overriding goal of the child protection process and of the organizational model; namely,

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*It is conceivable that the investigation function of the intake/investigation staff may be by-passed in some instances, e.g., treatment workers' observations during in-home visits and/or referral from hospital social service personnel. In such instances, however, it would seem necessary that case identifying and background information become a part of the intake files. Problems from this failure to document such cases in intake were noted in the PSU recordkeeping procedures.

the orderly sequencing of services to children and families by specified staff, it would appear appropriate for the intake/investigation staff to perform intake and investigation functions and to deliver short-term services designed to stabilize the immediate crisis. Short of this, the intake unit, as observed in the CES system, can easily become responsible for long-term case handling.

24-Hour Intake.–When intake into the protective service delivery system is restricted to the work day five days a week, cases handled generally by law officers after work day hours and on weekends would take a longer period of time between complaint and protective service involvement. Beyond this, the protective service agency might become involved in cases after parents have been jailed and the child/children have been inappropriately "disposed of." In such situations, the investigation and assessment procedures can be unduly prolonged. The absence of 24-hour intake may contribute to a back-log of cases for the intake/investigation staff.

Lends Itself to a Discriminatory Response Pattern.–A major requirement for a discriminating response pattern by the intake/investigation staff is the efficient and expeditious movement of cases from the intake unit. Beyond this requirement, is the need for a highly trained intake/investigation staff. Such staff should be well trained in interviewing skills and knowledgeable about presenting signs and symptoms of abuse and neglect complaints.

The staff must be able to solicit the necessary information from the complainant, and able to sort out and assess the facts for problem definition and subsequent case action. Do the facts indicate routine procedures or is emergency intervention warranted?

In addition to a highly trained and knowledgeable staff, the staff should be adequate in terms of the volume of inflow cases. An inadequate staff for the intake/investigation processes would provide for the delay in response to or total exclusion of some valid cases of abuse and neglect.

Aside from the time element in a discriminating response pattern is the whole issue of the pattern of services rendered. Following an investigation(s), decisions must be made to ensure an adequate response to the situation. Should the child be removed from the home in view of imminent risks to his health and/or safety? Can the child remain in the home with the stabilizing presence of an emergency caretaker or homemaker? Should the child be allowed to remain in the home with services? The intake/investigation staff encounters many situations in which placement or some other disposition could be avoided if emergency services, e.g., caretaker or homemaker, were available.

Such staff must have access to the same array of services made available to treatment staff if it is to deliver services appropriate to the demands of the situation.

Enhances Case Handling/Management-Treatment Services.–The goal in service delivery after entry into the system can be considered five-fold:

1. To eliminate recidivism;
2. Should incidents recur, to prolong the period between them;
3. To prevent subsequent serious harm;
4. To rehabilitate the perpetrator (parent); and
5. To avoid moving toward more severe dispositions; e.g., court action, placement.

The eventual overall goal of protecting children from subsequent harm as indicated by numbers 1-3 and 5, can only be reached if the goal of rehabilitating the parent and ameliorating familial circumstances is obtained. Should this goal--rehabilitation of the parent(s)--not be realized, failure is imminent.

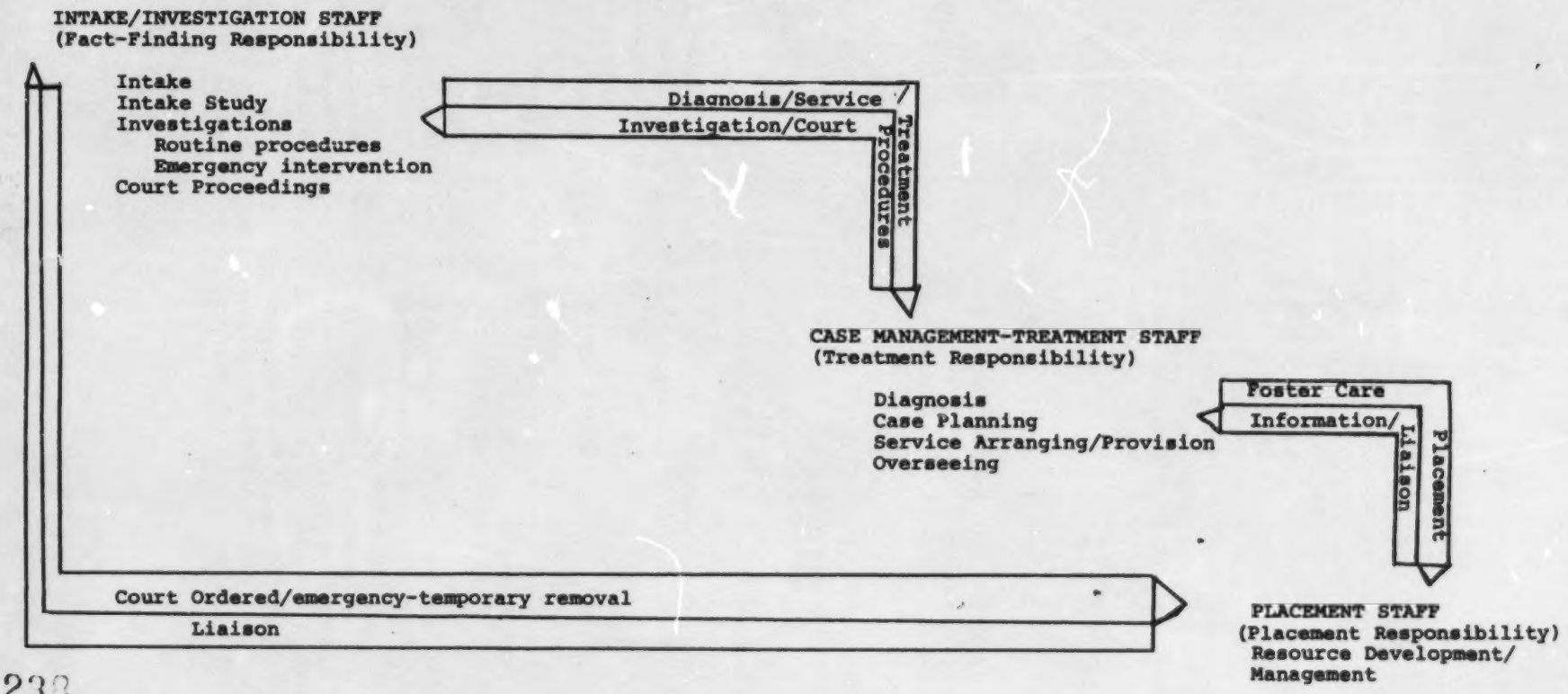
In order that the treatment staff in this model can provide intensive and effective services they must be freed from the intake/investigation function. Treatment staff need to be highly trained in the areas of human behavior and protective services, knowledgeable about community services, freed from heavy caseloads, and they must adhere to the protective service process.

Recruitment and Training of Specialized Staff.–As indicated earlier, perhaps there are different roles, qualifications, and training needs of staffs performing the different functions in the protection process. Some staff may feel more comfortable in an authoritative/investigative functional area while others may be more effective in the helping/treatment area. Given these possibilities an agency can recruit and train staff around individualized interests and specialized needs.

The stage for such a focus in recruitment and training, however, can only be set if the agency accepts the possibility

FIGURE 6-2

Proposed Organizational Model
(Major Functions and Relationships Indicated)



of differential staff needs, is committed to dealing effectively with child abuse and neglect cases, allocates appropriate funds, and provides the necessary training.

Continuity and Coordination of Care to Children and Families.--Whether children are allowed to remain in their own homes after a reported incident or whether they are removed, the problems leading to or making abuse and/or neglect imminent must be dealt with.

The removal of the child solves nothing. Yet, the parents of children in temporary placement (which often extends into long-term placement) have all too often been written off by the agencies--generally, no services are provided. It was indicated by personnel in both study sites that any efforts toward "rehabilitation" occurred just prior to the anticipated return of children to the home in preparation for that return. In the absence of services to these parents, where is the logic to the notion that the abuse and/or neglect will not recur after the return?

Given the fact that recidivism is at a high rate for children who have not previously been removed from the home, as well as for those who have been, it must be concluded that either families cannot be rehabilitated or that, while they are capable of being rehabilitated, efforts have been a failure.

Part of the failure can undoubtedly be attributed to the lack of continuity of care by the service provider(s) and the lack of coordination of the services rendered. This model provides for continuity of care in that the same worker(s) would be responsible to the child and family throughout the case handling/management-treatment process. Beyond this, the treatment staff would coordinate the efforts of all relevant resource providers.

Given the features of both models presented it appears reasonable to assume more success in retaining staff overtime providing for continuity of care in a more absolute sense as well as for more coordination of the efforts of service providers.

Concluding Remarks and Recommendations

A host of interrelated factors contribute to the dilemmas made evident by the data. If these are indeed problems of the agencies concerned, then they are problems over which these and others like them have little control and little hope for instant resolution. In one degree or another, I suspect that these problems typify child protective services.

This sad commentary is not intended as a sweeping criticism of the CES concept or as a negation of the value of implementing CES or any other "innovative" effort toward the goal of child protection. Instead, the findings from this study should serve as a reminder that "innovation" per se will not necessarily result in a cure-all package.

Recommendations

1. At the time of the study, the CES project was:

> . . .defined as a child welfare service designed to meet *any family crisis or impending crisis which requires social intervention* for the purpose of planning to protect children whose health, safety, and/or welfare is endangered *with primary emphasis on those children who will reach the attention of the Juvenile Court*, as neglected, unless there is immediate casework intervention (emphasis added).[6]

While risking repetition, we believe it is worth briefly re-stating the definition and logic for case exclusion for the present study. We excluded all cases which resulted from one or more of the following:

1. Accidental injuries;
2. Neglect due to family illness/hospitalization;
3. Family crisis which could have negative consequences for familial stability, e.g., death, unemployment, etc.; and
4. Personal report involving voluntary placement in the absence of abuse and neglect.

The logic for the exclusion of the above types of cases was two-fold:

1. Such cases were not handled by Savannah's PSU system; and
2. While the welfare of children and their families

[6] *Comprehensive Emergency Services: Community Guide*, p. 1.

are at stake in such cases, the decisions made and the treatment required are decidely different from that involved in cases generally defined as abuse and neglect.

Given the focus of CES as incorporated in the purpose statement, and the diversity of actual types of cases handled as determined by Institute staff during the data collection process, we can conclude that the success or lack of success accorded CES with abused and neglected children and families is confounded by the fact that data relating the success story result from a diverse population of neglected and dependent children. This conclusion is partially supported by the findings of Burt and Balyeat's evaluation of the demonstration program. According to their data, the hospitalization and/or illness of mother accounted for 40.0 percent of the reasons for the assignment of a home-maker. Relief to foster parents accounted for an additional twenty-five percent.[7]

While it is indeed a credit to any community system that can deflect any child from the Juvenile Court system, and where possible maintain him/her in their own home, it is both illogical and dangerous to apply success in this direction, i.e., with children who are not abused and neglected in the "true" sense, to make generalizable statements regarding probable success with the "truly" abused and neglected child. Thus, our first recommendation is that *communities must not expect a panacea in an innovative program. The implementation of a CES or any other such program should only be undertaken with the firm understanding regarding the ways in which such a program(s) can and presently does impact on child abuse and neglect.*

2. Our data and other existing knowledge demonstrate the utility and feasibility of CES for crisis intervention oriented to short-term placement and crisis resolutions; however, we believe that emergency intervention and ameliorative services *can not* be viewed as an end in itself, but merely a step toward the delivery of appropriate services.

   The success in the delivery of services to abused and/or neglected children involves appropriate decisions, actions, and services and at several junctures–the initial intervention being only one–in the total protection process. This implies that *a commitment to the protection of children and the rehabilitation of families involve more than simply buying into a crisis/emergency intervention system.*

3. The failure to rehabilitate parents is perhaps one of the most obvious indications (recidivism, seriousness in subsequent reports, short periods between reports, and agency tendency to move toward more severe dispositions are artifacts of the failure to rehabilitate parents and ameliorate familial circumstance) of failures in the service delivery process. A variety of factors undoubtedly contribute to the failure to rehabilitate parents, among which are:

   - *A lack of consistency, routine, and expertise in the diagnostic/problem definition process.*–In order to move toward more effective planning for problem resolution it is recommended that *the child protective service agency recognizes its own limitations in terms of staff, resources, and expertise, and move toward involving representatives from other professions on a consistent and routine basis in the diagnostic process.* The feasibility and success of "community input" at this stage in the protection process has been demonstrated.[8]

   - *Inadequately prepared and trained caseworkers.*– While there is no guarantee that a trained social worker will make a "good" CPS service provider nor that a good chemist will make a "bad" service provider, it seems logical to me (while I am aware of the contradictions in the literature regarding background and preparation) that some background in the human and behavioral sciences is better than none. Beyond background and orientation, it seems essential that protective service workers be provided intensive and on-going training. Therefore, it is recommended that *agencies attempt to recruit persons with backgrounds firmly based in the human and behavioral sciences and provide intensive and on-going training in the areas relevant to protective*

[7] Marvin R. Burt and Ralph Balyeat, "A New System for Improving the Care of Neglected and Abused Children," *Child Welfare*, Vol. LIII, No. 3 (March, 1974), pp. 167-179.

[8] Frank Barry, "Interdisciplinary Consultant Teams Spread," *Family Life Developments: A Resource from the Family Life Center* (Ithaca, N.Y.: No. 7, February, 1977), Newsletter.

services. This recommendation has not been made without knowledge of the obstacles agencies encounter in the hiring process (lack of sufficient appropriated funds, salary ceilings, high turn over of staff, availability of adequately prepared staff, etc.). Again, it is important to emphasize the interrelatedness of the factors involved in the response to the problem of child abuse and neglect and the fact that there is not a single and/or immediate resolution.

- *Inadequacies in staffing of protective services which limit the intensity, consistency, and coordination in service provision as indicated by the service needs.*--The planning step appears to be an appropriate stage in the child protection process at which the agency might involve the community. Representatives from other agencies presently involved with the family and/or will be involved as a result of the identified needs can assist the agency as a team to work with the family on a long-term basis. Therefore, we recommend that *protective service agencies develop policies and procedures for the appropriate utilization of interdisciplinary teams in the planning and service arrangement/delivery processes*. Beyond this, parents and children, where feasible, should be involved in case planning.

4. Data from the present study support the commonly held notion that children are often left in homes and/or returned where they continue to be maltreated--and in a sizeable proportion, more seriously so in subsequent incidents--while child protection workers "work" with the family. Among the factors felt to contribute to this failure in the child protection process are:

   - *Inadequate guides (criteria) for determining the appropriate response and action in specific kinds of situations.*--Our data strongly suggest that there are no consistent decision-making rules regarding case actions. Beyond the aforementioned need for a diffusion of the responsibility for case diagnosis and planning, adequately prepared staff, and the need for intensive and on-going training in the area of child protection, *child protection agencies need to take inventory of the various functions they perform in the protection process, the needs so related, and advocate for the development of the kinds of guides (criteria) so sorely needed to direct their expected behaviors.*

   - *Inadequacies in staffing which limit warranted case monitoring or surveillance.*--The most often expressed reason for the failure to make frequent contacts with families in which children are under "protective supervision" is that of the lack of time and/or manpower. In our recent experiences in training Head Start personnel from the eight states in Region IV, we found that an overwhelming majority of the trainees indicated a willingness to serve as monitors in a case plan in protective service cases. These trainees indicated that home visitation was presently a vital part of their program. Thus, it is recommended that *protective service agencies make more extensive use of the various community resources providing services and/or will provide services as mandated by the case plan in an effort to move toward a more comprehensive and coordinated delivery service package. Beyond this, external resource providers may assume some of the direct responsibility for monitoring occurrences and progress within the family.*

   - *Agencies' philosophy of maintaining children in their own home and the emphasis upon rehabilitating parents (at times, children's immediate safety is jeopardized).*--Ideally, it is preferable to maintain children in their own homes when possible; however, it is recommended that when this philosophical stance may serve to the detriment of children, *agencies must exercise their authority and remove children who, if allowed to remain in the home, might be subjected to serious harm.*

     Our data suggest that removal was often effected for less than probable cause; on the other hand, some children were allowed to remain in the home in spite of apparent cause for removal.

     We feel that considerable thought and more deliberate guided action must be exercised in the whole intervention process, particularly to ensure that children will not be removed from their homes unless their safety (serious harm) is jeopardized. By the same token, children who are seriously harmed and/or are at risk of serious harm should not be allowed to remain in the home. Perhaps in time, with the development of more effective decision-making

guides, a better match of services to problem(s) need, and effective monitoring procedures, the desired goal of maintaining children in their own home can be realized.

- *The practice of returning children to the home after placement (short and long periods) with little or no interim services to the families.*--Personnel in both study sites indicated that efforts which were designed to "rehabilitate" parents occurred just prior to the anticipated return of children to the home in preparation for their return. Without the provision of services, one might assume that the problems leading to or making abuse and/or neglect imminent would still exist when children are returned.

  Without ameliorative services to the parent(s) during placement there is no logic to the return. Therefore, we recommend that *parents of children in placement be handled by the case management-treatment staff such that the assessment-monitoring cycle is implemented in the same proposed manner as in-own-home cases. Beyond this, services to children in foster care placements should be provided by the case management staff.*

  The focus of the "treatment" should be on the behaviors of both parents and children. To focus on changing parents' behaviors without concomitant consideration of the changed behaviors of children--partially due to the maltreatment, the removal process, and the actual placement--is to deal with a part of the total relationship. To deal with one out of context of the other sets the stage for further maltreatment upon the return of children.

5. The present target for training and specialization in service delivery is on that identified staff which assumes the responsibility for intake/investigation and emergency intervention. There is no doubt, however, that the failure to rehabilitate parents and consequently the failures depicted by other criteria are due primarily to efforts, or the lack thereof, in the assessment-monitoring cycle of the child protection process. Therefore, it is recommended that *staff responsible for the case handling/management-treatment process be viewed as specialists in the child protection process and as such be recruited and trained with that consideration in mind.*

6. The process model which has been presented warrants a high degree of inter-and intra-agency cooperation and coordination. The need for and the failure to obtain cooperative and coordinated linkages is an age-old problem. There is no reason to feel that any suggestion will be a fail-safe plan; however, toward the goal of moving in the suggested direction it is recommended that *special training be developed and implemented to establish procedures and a structure for joint decisions involving personnel from different agencies, professional backgrounds, and philosophical orientations.* Beyond this, training in the specialized area of child protection must be provided to all disciplines and agencies involved in a community's protection of children.

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